COVID-19 Test Requisition

All sections outlined in red MUST be completed

1 - Submitter Lab Number (if applicable):

Ordering Clinician (required)

Surname, First Name:

OHIP/CPSO/Prof. License No:

Address:

Postal code:

Phone: (###) ###-#### Fax: (###) ###-####

cc **Hospital Lab (for entry into LIS)**

Hospital Name:

Address (if different from ordering clinician):

Postal Code:

Phone: (###) ###-#### Fax: (###) ###-####

cc **Other Clinician or ICP:**

Surname, First name:

OHIP/CPSO/Prof. License No.:

Address:

Postal code:

Phone: (###) ###-#### Fax: (###) ###-####

Enter **name and license number** for **clinician ordering the test** (for license numbers refer to practitioner extract)

ALL fields in Box 2 **Patient Information** MUST BE ENTERED.

Note:

- **Health Card No.:** when unavailable, enter a MRN
- **Address:** FULL address of location where patient is residing
- **Phone number –** of the shared living facility to facilitate PHU follow-up
- **Investigation/Outbreak No**: facility specific

Enter name of **Primary Care Doctor** in **Other Clinician** so they can be authorized to receive results electronically (i.e., HRM) if enabled. Use accepted values as outlined in practitioner extract.

Provide details on **Travel** and **Exposure History** if available

2 - Patient Information

Health Card No.:

Medical Record No.:

Last Name:

First Name:

Date of Birth: yyyy / mm / dd Sex: M F

Address:

Postal Code:

Patient Phone No.: (###) ###-####

Investigation / Outbreak No.:

3 - Travel History

Travel to:

Date of Travel: yyyy / mm / dd Date of Return: yyyy / mm / dd

4 - Exposure History

Exposure to probable, or confirmed case? Yes No

Exposure details:

Date of symptom onset of contact: yyyy / mm / dd

5 - Test(s) Requested

☑ COVID-19 Virus

☐ Respiratory viruses check **ONLY** if required for hospitalized patient or those in group setting)

All sections outlined in red MUST be completed

7 - Patient Setting / Type

- Assessment Centre
- Family doctor/clinic
- Outpatient/ER not admitted

Only if applicable, indicate the group:

- Healthcare worker
- Inpatient (hospitalized)
- Inpatient (ICU/CCU)
- First Nations / Inuit
- Unhoused / shelter
- ER - to be hospitalized
- Deceased / Autopsy
- Institution / all group living settings
- Confirmation (for use **ONLY** by a COVID testing lab). Enter your result (NEG/POS/or IND)
- For clearance of disease
- Other (Specify):

All sections: Patient Setting and Type boxes MUST BE COMPLETED to support organizing and reporting of data.

- **Patient Location** – select where the patient/worker was tested, or specify 'other' location
- **Group** – select most appropriate group for the patient

6 - Specimen Type (check all that apply)

Specimen Collection Date: yyyy / mm / dd **(required)**

- NPS in UTM
- Throat Swab in UTM
- Other (Specify):

If possible:

- BAL
- Sputum

8 - Clinical Information

- Asymptomatic
- Symptomatic

Date of symptom onset: yyyy / mm / dd

- Fever / temperature, if known:
- Pregnant / also check if in labour:
- Pneumonia
- Cough
- Sore Throat
- Other (specify):

Specimen Collection Date and **Symptom Status** MUST BE COMPLETED

If patient is symptomatic, enter **date of symptom onset,** select all applicable **symptoms** and enter **Other** symptoms or additional details (e.g., temperature)

Practitioner extract available at:
https://www.ehealthontario.on.ca/en/practitionerextract/request