London Health Sciences Centre — Microbiology

COVID-19 VIRUS TEST REQUISITION

ALL sections of this form must be completed at every visit

1. REFERRING PHYSICIAN INFORMATION

Physician Name:

Phone Number:

Fax Number:

CPSO Number:

Accession No:

Institution/ Facility:

Address:

City:

Province: ON Postal Code:

Health Unit Name:

Health Unit Outbreak No.:

2. PATIENT INFORMATION

Health Card No.: Medical Record No.:

First Name:

Last Name:

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

Address:

Postal Code: Patient Phone No.:

3. TRAVEL HISTORY

Travel to:

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

4. EXPOSURE HISTORY

Exposure to PUI, probable or confirmed case? ◯ Yes ◯ No

Exposure Details:

Date of return of contact (if travelled): yyyy/mm/dd

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

5. TEST(S) REQUESTED

COVID-19 Diagnostic	◯ Yes	◯ No
COVID-19 Screen	◯ Yes	◯ No
Respiratory Virus PCR	◯ Yes	◯ No

See testing guidelines

6. SPECIMEN TYPE (CHECK ALL THAT APPLY)

Specimen Collection Date/Time:

☐ NPS in UTM

☐ Throat Swab in UTM

☐ Nasal/Mid-turbinate

☐ Other:

If possible:

☐ BAL

☐ Sputum

7. PATIENT SETTING

☐ Physician office/clinic

☐ ER (not admitted)

☐ Inpatient (ward)

☐ Assessment Centre

☐ Inpatient (ICU)

☐ Institution

☐ Healthcare Worker

8. CLINICAL INFORMATION:

☐ Asymptomatic ☐ Symptomatic

Date of symptom onset: yyyy/mm/dd

☐ Fever Temperature (if know):

☐ Cough ☐ Shortness of breath

☐ Sore Throat ☐ Pneumonia

☐ Other (specify) :

9. WILL PATIENT BE HOSPITALIZED?

◯ Yes ◯ No