Public Health Ontario COVID-19 and Respiratory Virus Test Requisition

For laboratory use only Date received (yyyy/mm/dd):

PHOL No.:

Virus Test Requisition			ALL Sections of this form must be completed at every visit			
1 - Submitter Lab Number (if applicable):			2 - Patient Information			
Ordering Clinician (required)			Health Card No.:	Me	edical Record No.:	
Surname, First Name:			Last Name:			
OHIP/CPSO/Prof. License No:						
Name of clinic/ facility/health unit:			First Name:			
Address:	F	Postal code:	Date of Birth (yyyy/mm/dd):		Sex: M F	
			Address:			
Phone:	F	ax:				
cc Hospital Lab (for	entry into LIS)		Postal Code:	P	atient Phone No.:	
Hospital Name:			Investigation or Outbreak No.:			
Address (if different from ordering clinician):			3 - Travel History			
Postal Code:			Travel to:			
Phone:	F	ax:	Date of Travel (yyyy/mm/dd):		ate of Return /yyy/mm/dd):	
cc Other Authorized	Health Care Provi	der:	4 - Exposure History			
Surname, First name:			Exposure to probable, Yes No or confirmed case? Exposure			
OHIP/CPSO/Prof. License No.:						
Name of clinic/ facility/health unit:			details:	of contact (\\\\	w/mm/dd):	
Address: Postal code:			Date of symptom onset of contact (yyyy/mm/dd): 5 - Test(s) Requested			
Phone: Fax:		COVID-19	Respirato	ry COVID-19 Virus AND Respiratory		
			Virus	Viruses		
6 - Specimen Type (check all that apply) Specimen Collection Date (yyy/mm/dd): (required)			7 - Patient Setting Assessment	Family	Outpatient / ER	
-		(required)	Centre	doctor / c		
NPS	Throat Swab	Saliva (Swish & Gargle)	Only if applicable, indicate	the group:		
Deep or Mid-turbinate	Throat + Nasal	Saliva (Neat)	ER - to be hospitaliz	ed	Deceased / Autopsy	
Nasal Swab	BAL	Anterior Nasal (Nose)	Healthcare worker		Institution / all group living settings	
Oral (Buccal) + Deep Nasal	Other (Specify):		Inpatient (Hospitalize	ed)	Facility Name:	
8 - COVID-19 Vaccination Status			Inpatient (ICU / CCU) Confirmation (for use ONLY			
Received all required doses >14 days ago			Remote Community	by a COVID testing lab). Enter your result (NEG / POS / or IND):		
9 - Clinical Information			Unhoused / Shelter			
Asymptomatic	Fever	Pregnant	Other (Specify):			
Symptomatic	Pneumonia	Other (Specify):	CONFIDENTIAL WHEN			
Date of symptom onset (yyyy/mm/dd):	Cough Sore Throat		The personal health information is collected under the authority of the Personal Health Information Protection Act, s.36(1)(c)(iii) for the purpose of clinical laboratory testing. If you have questions about the collection of this personal health information please contact the PHO laboratory Manager of Customer Service at 416-235-6556 or toll free 1-877-604-4567. Form No. F-SD-SCG-4000 (21/07/22).			