

Assessment Centre Instructions 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: (###) ###-####

Hospital Lab (for entry into LIS)

Hospital Name: _____

Address (if different from ordering clinician): _____

Postal Code: _____

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

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:** if unavailable, enter a MRN
- **Address:** FULL address of location where patient is residing
- **Postal Code** required to validate health unit
- **Phone number** – of the shared living facility to facilitate PHU followup
- **Investigation/Outbreak No:** event 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)

7 - Patient Setting / Type

<input type="checkbox"/> Assessment Centre	<input type="checkbox"/> Family doctor/clinic	<input type="checkbox"/> Outpatient/ER not admitted
Only if applicable, indicate the group:		
<input type="checkbox"/> Healthcare worker	<input type="checkbox"/> Institution / all group living settings	
<input type="checkbox"/> Inpatient (hospitalized)	<input type="checkbox"/> Confirmation (for use ONLY by a COVID testing lab). Enter your result (NEG/POS/or IND)	
<input type="checkbox"/> Inpatient (ICU/CCU)	<input type="checkbox"/> For clearance of disease	
<input type="checkbox"/> First Nations / Inuit	<input type="checkbox"/> Other (Specify):	
<input type="checkbox"/> Unhoused / shelter		
<input type="checkbox"/> ER - to be hospitalized		
<input type="checkbox"/> Deceased / Autopsy		

All sections outlined in red MUST be completed

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

- **Patient Location** – select where the patient/worker was tested
- **Group** – select most appropriate group for the patient
- **Other** - enter the **COVID-19 Mobile Testing Unique ID** (e.g. LTC-1001) as outlined in [Shared Living Centre reference table available](#). Only these IDs must be used.
- Pre-print the COVID-19 Mobile Testing Unique ID on the requisition form if possible.

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)

6 - Specimen Type (check all that apply)

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

<input type="checkbox"/> NPS in UTM	If possible:
<input type="checkbox"/> Throat Swab in UTM	<input type="checkbox"/> BAL
<input type="checkbox"/> Other (Specify):	<input type="checkbox"/> Sputum

8 - Clinical Information

Asymptomatic Symptomatic

Date of symptom onset: yyyy / mm / dd

<input type="checkbox"/> Fever / temperature, if known:	<input type="checkbox"/> Pneumonia	⊕
<input type="checkbox"/> Pregnant / also check if in labour:	<input type="checkbox"/> Cough	
	<input type="checkbox"/> Sore Throat	
<input type="checkbox"/> Other (specify):		+

Practitioner extract available at:

<https://www.ehealthontario.on.ca/en/practitionerextract/request>

Shared Living Centre reference table available at:

https://www.ehealthontario.on.ca/images/uploads/support/Shared-Living_AssessCtr_COVID-19.xlsx