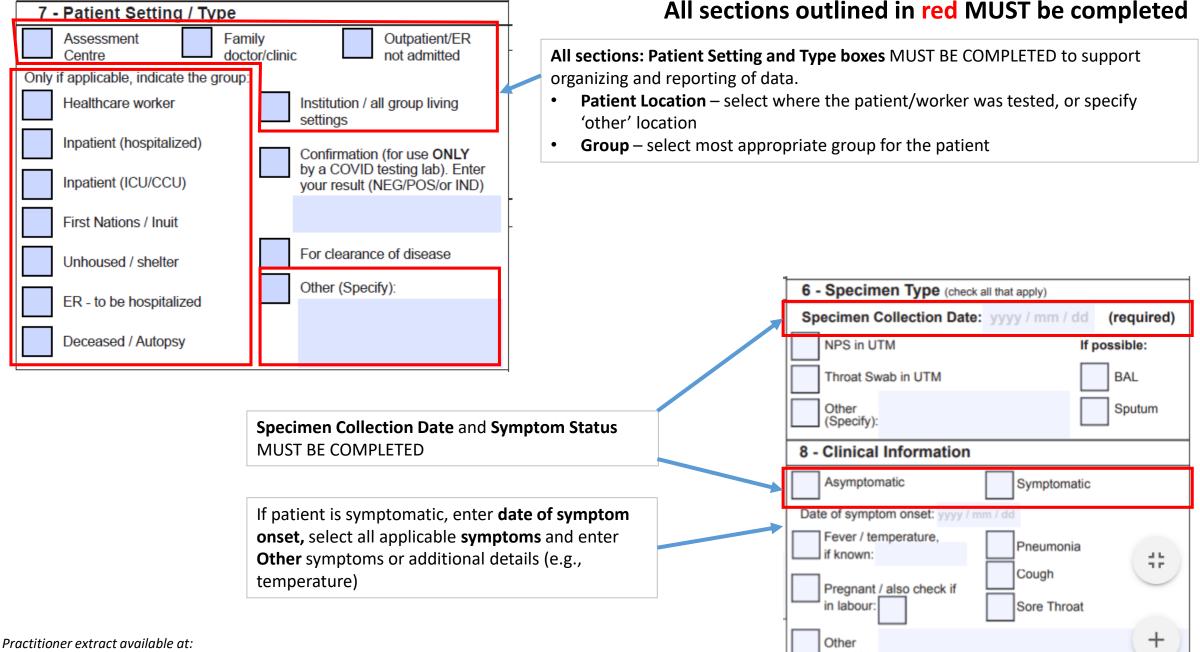
COVID-19 Test Requisition

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)		2 - Patient Information		
_				Health Card No.:	Medical Record No.:	
				Last Name:		
		 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.		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		
		Provide details on Travel and Exposure History if available		5 - Test(s) Requested COVID-19 Virus	Respiratory viruses check ONLY if required for hospitalized patient or those in group setting)	
				V COVID-18 virus	patient or those in group	



(specify):

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