

Public Health Ontario | Santé publique Ontario
COVID-19 and Respiratory Virus Test Requisition

For laboratory use only	
Date received (yyyy/mm/dd):	PHOL No.:

ALL Sections of this form must be completed at every visit

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 or 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	COVID-19 Virus AND Respiratory Viruses
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7 - Patient Setting / Type

Assessment Centre	Family doctor / clinic	Outpatient / ER not admitted
Only if applicable, indicate the group:		
ER - to be hospitalized	Deceased / Autopsy	
Healthcare worker	Institution / all group living settings	
Inpatient (Hospitalized)	Facility Name:	
Inpatient (ICU / CCU)	Confirmation (for use ONLY by a COVID testing lab). Enter your result (NEG / POS / or IND):	
Remote Community		
Unhoused / Shelter		
Other (Specify):		

CONFIDENTIAL WHEN COMPLETED
 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).

1 - Submitter Lab Number (if applicable):

Ordering Clinician (required)
 Surname, First Name:
 OHIP/CPSO/Prof. License No.:
 Name of clinic/facility/health unit:
 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 Authorized Health Care Provider:
 Surname, First name:
 OHIP/CPSO/Prof. License No.:
 Name of clinic/facility/health unit:
 Address: Postal code:
 Phone: Fax:

6 - Specimen Type (check all that apply)

Specimen Collection Date (yyyy/mm/dd):	(required)	
NPS	Throat Swab	Saliva (Swish & Gargle)
Deep or Mid-turbinate Nasal Swab	Throat + Nasal	Saliva (Neat)
	BAL	Anterior Nasal (Nose)
Oral (Buccal) + Deep Nasal	Other (Specify):	

8 - COVID-19 Vaccination Status

Received all required doses >14 days ago	Unimmunized / partial series / ≤14 days after final dose	Unknown
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9 - Clinical Information

Asymptomatic	Fever	Pregnant
Symptomatic	Pneumonia	Other (Specify):
Date of symptom onset (yyyy/mm/dd):	Cough	Sore Throat