Quest+Medi Lab

4282 91A Street NW, Edmonton, AB T6E5V2, Tel: 780 851 2012 Ext 101

For laboratory use only Date and Time sample received (yyyy/mm/dd): hh:mm

Lab Code No.:

COVID-19 and Respiratory Virus Test Requisition

ALL Sections of this form must be completed at every visit

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:

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

6 - Specimen Type (check all that apply) Collection Date (yyyy/mm/dd):

Collection Time (hh:mm)

☐ 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):

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):

8 - COVID-19 Vaccination Status

◯ Received all required doses >14 days ago ◯ Unimmunized / partial series / ≤14 days after final dose ◯ Unknown

9 - Clinical Information

☐ Asymptomatic ☐ Fever ☐ Pregnant

☐ Symptomatic ☐ Pneumonia ☐ Other (Specify):

Date of symptom onset (yyyy/mm/dd):

☐ Cough

☐ Sore Throat

Patient's Signature

CONFIDENTIAL WHEN COMPLETED

The personal health information is collected under the authority of the Personal Health Information Protection Act for the purpose of clinical laboratory testing.

Form No. QRAMEDI-2002

Authorized by: D. Bhaumick Date Issued: July 04, 2022 Revision Number: 01 Date Revised: June 23, 2023
Location of the form: Form Folder in QRA Server