Public Health Ontario | Santé publique Ontario

COVID-19 Serology Test Requisition

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

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 ☐ **Other 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 / Outbreak No.:

3. Patient Setting

☐ Family Doctor / Clinic
☐ Outpatient / ER not admitted
☐ Inpatient (hospitalized)
☐ Inpatient (ICU / CCU / NICU)

4. Test(s) Requested

☑ SARS-CoV-2 IgG

5. Specimen Type

Specimen Collection Date (yyyy/mm/dd): (required)
☐ Serum / Clotted Blood
☐ Other (specify):

6. Reason for test

☐ Suspected Multisystem Inflammatory Syndrome in Children (MIS-C)

Other reason requires PHO approval. Contact PHO at +1-877-604-4567.

7. COVID-19 PCR Result(s)

COVID-19 PCR Test Result 1:
☐ POS ☐ NEG ☐ Indeterminate ☐ Not Tested
PCR Test Date 1 (yyyy/mm/dd):
COVID-19 PCR Test Result 2 (if applicable):
☐ POS ☐ NEG ☐ Indeterminate
PCR Test Date 2 (yyyy/mm/dd):

8. Exposure & Travel History

If not tested, was the patient exposed to a confirmed or probable COVID-19 case? ◯ YES ◯ NO ◯ UNKNOWN
Date of Exposure (yyyy/mm/dd):
Travel: ◯ YES ◯ NO
If YES, travel to:
Date of Travel (yyyy/mm/dd):
Date of Return (yyyy/mm/dd):

9. Current Symptoms (check all that apply)

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

Indicate organ system involved:
☐ Cardiac ☐ Gastrointestinal ☐ Renal
☐ Hematologic ☐ Dermatologic ☐ Neurologic

Other:
☐ Fever (duration days) ☐ Conjunctivitis ☐ Shock / Hypotension
☐ Respiratory symptoms ☐ Laboratory evidence of inflammation
☐ Other (specify):

10. Other Medical History (check all that apply)

Comorbidities/medical conditions:
☐ Asthma ☐ Other chronic lung disease
☐ Diabetes ☐ Severe obesity (BMI ≥40)
☐ Liver disease ☐ Pregnant
☐ Chronic kidney disease requiring dialysis
☐ Other:

Immunocompromised: ◯ YES ◯ NO
If YES, describe:

Any receipt of blood products in previous 6 months e.g. IVIG:
◯ YES ◯ NO
If YES, product received:
Date of administration (yyyy/mm/dd):
Other treatment(s):

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-4010 (07/31).*

Ontario