

MICROBIOLOGY

*****All Fields are Mandatory. Please Complete Fields Clearly in Full to Avoid Delay in Reporting Results*****

Patient Information (Please Complete)

Group (Check box)*:** Student
 Camper Staff Family Member Resident Other: _____

Last Name*** _____

First Name*** _____

Parent/Guardian/Caregiver Name*** _____

Date of Birth (yyyy/mm/dd)*** _____
 Home Mailing Address: No fixed address

Sex assigned at Birth***: Male Female

Patient Setting*** School Camp
 Shelter/Congregate Childcare centre
 Other: _____

Postal Code*** _____
 Telephone Number*** _____

Setting Name*** (Specify full name of school/centre/site)

For Ontario Residents Only ***

NO OHIP **RED & WHITE OHIP CARD**

Provincial Health#: _____ **Version** _____

Specimen Collection Information***

Date (YYYY/MM/DD): _____ **Time (HH:MM):** _____ **Specimen Type** **SALIVA (neat)**

Asymptomatic (no symptoms) Symptomatic (specify): Fever Pneumonia Cough Sore Throat
 Date of onset of symptoms (yyyy/mm/dd): _____ Other (specify): _____

Outbreak/Investigation # (if known): _____

Travel / Exposure History***

Travel to: N/A **Exposure to possible or confirmed case** Yes No
 (if yes, complete below)

Date of Travel: (YYYY/MM/DD) _____ Date of Return: (YYYY/MM/DD) _____ Date of symptom onset of contact: _____
 Details: _____

COVID-19 Vaccination Status
 Received all doses >14 days ago
 No vaccination/parital dosage series/< 14 days after final dose

TEST (LAB USE ONLY)

Submitter: SK THE HOSPITAL FOR SICK CHILDREN	Ordering Physician: Dr. Julia Orkin
	OHIP/CPSO/Prof. License number: 027153/86355
Test: MOBILE TESTING UNIT COVID-19 RT PCR	LAB 11340