SickKids
THE HOSPITAL FOR SICK CHILDREN

MICROBIOLOGY-COVID LABORATORY
555 University Avenue
Room 3513, Atrium
Toronto, ON, M5G 1X8, Canada
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Fax: 416-813-5413

LABORATORY REQUISITION FOR COVID-19 TESTING

***ALL FIELDS ARE MANDATORY. Complete Fields Clearly in Full to Avoid Delay in Reporting

For Ontario Residents Only | NO OHIP ☐ RED & WHITE OHIP CARD ☐

Provincial Health#: 1234567891 (10 digits) | **Version:** XX (two letters)

Patient Information

Last Name: Doe

First Name: Jane

Parent/Guardian/Caregiver Name: John Doe

Date of Birth: (dd/mm/yyyy) 06/08/2001

Sex assigned at Birth: ☐ Male ☒ Female

Home Mailing Address: ☐ No fixed address

123 Street
City,
Province

Email address: john.doe@email.com

Postal Code: A1B 2C3

Telephone Number: 416-123-4567

Group (Check box): ☒ Student ☐ Camper ☐ Staff ☐ CMC ☐ Resident ☐ Family Member ☐ SK-Family Member ☐ Other: _____

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

Setting Name: (Specify full name of school/centre/site)
School X

Outbreak/Investigation # (if known): _____

☐ **Asymptomatic (no symptoms)** ☒ **Symptomatic (specify):** ☐ Fever ☒ Sore Throat ☐ Cough ☐ Nausea ☐ Vomitting ☐ Diarrhea ☐ Other (specify): _____

Date of onset of symptoms (dd/mm/yyyy): 01/01/2021

COVID-19 Vaccination Status

Received: ☒ No vaccination ☐ Two doses more than 14 days ago

Specimen Collection Information

Date (dd/mm/yyyy): 01/03/2021 | **Time** (HH:MM): 11:15am | **Specimen Type:** Saliva (neat)

Exposure History

Exposure to possible or confirmed case	☐ Yes ☒ No	Date of symptom onset of contact:
		Details:

TEST (LAB USE ONLY)

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