SickKids
THE HOSPITAL FOR SICK CHILDREN

MICROBIOLOGY-COVID LABORATORY
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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