

# COVID-19 VIRUS REQUEST FORM (2020)

Address for Non-PEI Residents Required

**Provincial Microbiology Laboratory**  
**Queen Elizabeth Hospital**  
**Charlottetown, PEI**  
**Phone (902)894-2312 Fax (902)894-2120**

Name: \_\_\_\_\_  
 Street: **Place Label Here**  
 City: \_\_\_\_\_ Prov./State: \_\_\_\_\_  
 Postal Code/Zip: \_\_\_\_\_ Patient Phone # \_\_\_\_\_

<b>Specimen Collected</b> By: _____ Date (YYYY/MM/DD): _____ Time (HH:MM): _____	<b>Payment Responsibility</b> <input type="checkbox"/> WCB <input type="checkbox"/> DVA <input type="checkbox"/> DND <input type="checkbox"/> RCMP <input type="checkbox"/> Self Pay Canadian <input type="checkbox"/> Self Pay Non-Canadian Provincial Medicare # exp. date: _____
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DOB: YYYY-MMM-DD	Sex	Medical Record Number (MRN)
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**Ordering MD:** CHIEF HEALTH OFFICER ( CHO )   **Alternative ordering MD/NP:** \_\_\_\_\_

**Location of Collection:**

Charlottetown    Summerside    Borden    O'Leary    Montague    Other Site    Island EMS

**Specimen type:**

NP swab    Midturbinate    Midturbinate/throat  
 Nasal/Throat swab    Nasal    Saline Gargle

**Traveler History: (When/When)::**

Arriving from International [98]  
 Arriving from Outside Atlantic Bubble [99]  
 Departing for travel [23]  
 -->Passport Number: \_\_\_\_\_

**MANDATORY Clinical Information:**

**Symptomatic write "S" on tube**  
 **Not Symptomatic write "A" on tube**

**Exposure History:**  Outbreak OB: \_\_\_ & write on tube

Close Contact [16]  
 Confirmed Case [29]

Long term care resident [06]  
 Community care resident [07]  
 Palliative care resident [09]  
 Group home resident [08]  
 Mental Health and Addictions [10]  
 Correctional facility admission [14]  
 Other facility: \_\_\_\_\_

Health care provider (HCP)/family member [11]  
 Essential worker (EW)/family member [12]  
 --> Role of HCP/EW:: \_\_\_\_\_  
 Location:  
 Temporary Foreign Workers [13]  
 Screeners at point of entry [15]  
 K-12 Teacher / Staff [25]  
 K-12 Student [26]  
 UPEI/AVC Student [27]

Special request of the Chief Public Health Office or staff [19]  
 Explain: \_\_\_\_\_

None of the Above [17]

**Symptoms (check off any applicable symptoms below):**

<input type="checkbox"/> Fever * _____ °C	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Cough/ Worsening Cough
<input type="checkbox"/> Chills	<input type="checkbox"/> Headache	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Marked Fatigue	<input type="checkbox"/> Loss of taste/smell
<input type="checkbox"/> Other symptoms (list): _____	<b>* Fever in Seniors are broadly defined</b>	

Assessment Performed by (signature): \_\_\_\_\_

Lab use only: \_\_\_\_\_

**Testing Site:** Cough & Fever Clinic: Yes  No   
 First Swab:  Repeat Swab: