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EML EUREKA MEDICAL LABORATORIES INC.

For laboratory use only.
Lab Accession #

SARS-CoV-2 (COVID-19) Test Requisition Form

ALL SECTIONS OF THIS FORM MUST BE COMPLETED AT EVERY VISIT

Patient Demographics

First Name: _____ Last Name: _____ Sex at birth ☐ M ☐ F Date of birth _____ *DD/MM/YYYY* Age ____

Address: _____ Reg. # ____ Patient phone #: _____ Patient email: _____ Place of Work _____

History

Travel History

Recent travel ☐ Y ☐ N Travel to and/or returned from: _____ Date of travel: _____ *DD/MM/YYYY* Date of return: _____ *DD/MM/YYYY*

Exposure History

Exposure to probable, or confirmed case? ☐ Y ☐ N Exposure details: _____ Date of exposure: _____ *DD/MM/YYYY*

Clinical History

☐ Asymptomatic
☐ Symptomatic

Symptoms:

☐ fever
☐ chills
☐ general weakness
☐ dry cough
☐ shortness of breath
☐ sore throat
☐ runny nose
☐ difficult breathing
☐ diarrhoea
☐ vomiting
☐ nausea
☐ irritability
☐ headache
☐ confusion
☐ pain _____
☐ other, specify _____

Date of symptom onset _____ *DD/MM/YYY*

Previous Antigen/PCR Test: ☐ Y ☐ N

Date: _____ *DD/MM/YYYY*

Result: _____

Purpose of test: ☐ Job ☐ Travel ☐ Other, specify _____ Travel date: _____ *DD/MM/YYYY* Travel Time: _____ ☐ AM ☐ PM

By signing this document, I hereby declare and confirm that the personal details, address, and clinical information that I have provided are complete, accurate and free of error. I bear the responsibility for the correctness of these details. I also hereby acknowledge that I have been informed that the results for my test will be available within 48 hours of providing my sample for testing.

SIGN HERE: _____ **DATE**: _____

Submitting Healthcare Provider Information

Submitting Physician

Name: _____ Signature: _____ Address: _____

Phone #: _____ Fax #: _____ Email: _____

OR Submitting Hospital/Clinic/Lab

Name: _____ Address: _____ Phone: _____

Primary contact Name: _____ Primary contact phone #: _____ Primary contact email: _____

Laboratory Information

Source/Specimen type

☐ NP swab
☐ Oropharyngeal swab
☐ Deep or Mid-turbinate Nasal Swab
☐ Bronchoalveolar lavage (BAL)
☐ Other, specify: _____

Test requested

☐ SARS-CoV-2 (COVID-19) RT-PCR Assay

Patient Status

☐ Walk-In
☐ Appointment

Priority

☐ Routine
☐ **Urgent**

Appointment Date: _____ *DD/MM/YYYY*

Appointment Time: _____ ☐ AM ☐ PM

Date to uplift results: _____ *DD/MM/YYYY*

Name of Collector: _____ **Signature of Collector:** _____ **Collection Date:** _____ ***DD/MM/YYYY*** **Collection Time:** _____ ☐ **AM** ☐ **PM**