COVID-19 and Other Respiratory Viruses Requisition
(Provincial)

Alberta Health Services

Edmonton Site 8440-112 St. T6G 2J2
Phone 780.407.7121 Fax 780.407.3864
Virologist/Microbiologist-on-call 780.407.8822

Calgary Site 3030 Hospital Dr NW T2N 4W4
Phone 403.944.1200 Fax 403.270.2216
Virologist/Microbiologist-on-call 403.944.1200

- **Full link of location codes:** *http://ahsweb.ca/lab/if-lab-covid-19-requisition-location-code-master-list*
- Consult the Site Virologist/Microbiologist-on-Call listed above for STAT requests, and when specified in the Guide to Services
- See the **Guide to Services** *https://www.albertahealthservices.ca/lab/page3317.aspx/education.htm* for information on sample type, transport and testing

Scanning Label or Accession # *(lab only)*

Patient

PHN Prov _____ Expiry _____		Date of Birth *(dd-Mon-yyyy)*	
Legal Last Name	Legal First Name	Middle Name	
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ X Non-binary/Prefer not to disclose	Phone
Address	City/Town	Prov	Postal Code

Provider(s)

Authorizing Provider Name		Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*	
Address	Phone	Address	Address	
CC Provider ID	Millennium ID / Sunquest ID	Phone	Phone	

Collection

Date Collected *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID	**Outbreak (EI)** *if applicable (yyyy-###)*

Specify Test

☐ COVID-19 only
☐ COVID-19 and Influenza A/B *(requires ILI symptoms)*
☐ COVID-19 and Respiratory Pathogen Panel (RPP) *(requires ILI symptoms and RPP criteria)*

Clinical History *(required)*

☐ Asymptomatic: no COVID-19 or ILI symptoms
☐ Influenza-like illness (ILI) symptoms *(e.g. cough, fever, myalgias)*
☐ Other COVID-19 symptoms *(e.g. diarrhea, headache, anosmia)*
Date of symptom onset _____ *(dd-Mon-yyyy)*

☐ Outpatient or pending discharge
☐ Hospital inpatient or pending admission

☐ Close contact to a known COVID-19 case

Respiratory Pathogen Panel (RPP) Criteria

☐ outbreak investigation *(indicate EI# in "Outbreak [EI]" field above)*
☐ critical respiratory failure
☐ severely immunocompromised *(e.g. transplant, chemotherapy)*
☐ myocarditis/pericarditis
☐ acute flaccid paralysis
☐ pre-transplant

Relevant travel history
(include countries and dates of return)
☐ No Travel

Relevant immunizations *(and dates)*

Specimen Source/Type

☐ nasopharyngeal swab ☐ nasopharyngeal aspirate ☐ endotracheal tube (ETT) aspirate
☐ throat swab ☐ bronchoalveolar lavage (BAL) ☐ bronchial wash (BW)
☐ other _____

Contact Preference for COVID-19 Results **Not available for urgent care, ER, inpatient, hospital ambulatory clinics, LTC/DSL**

☐ Text ☐ Automated Call ☐ Phone call from AHS Phone number: _____

Health Care Work and Facility Information

Health Care Worker? ☐ Yes ☐ No
Health Care Worker or Resident of **LTC/DSL** Facility? ☐ Yes ☐ No **If yes,** specify:
Full Facility Name **Location Code *(required)*** City or Town

_____ _____ _____