Alberta Health Services

COVID-19 Test Requisition
(Provincial)

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	
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ 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

Specimen/Type Source - Specify

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

Specify Other Serology and Molecular Tests	**Fluid**	**Swab**
☐ COVID-19 only	☐ Bronchoalveolar Lavage (BAL)	☐ Nasopharyngeal
☐ COVID-19/Respiratory Pathogen Panel	☐ Nasopharyngeal Aspirate	☐ Throat
	☐ Endotracheal Suction	

Provide Clinical History or Reason for Testing below - Completion of this section is required

Reason for Testing *(check one)* ☐ Symptomatic ☐ Asymptomatic Close Contact? ☐ Yes ☐ No	List Countries visited within past 3 months of symptom onset **OR** provide relevant travel history ☐ No Travel	
Date of onset of symptoms *(dd-Mon-yyyy)*		
Immunocompromised ☐ No ☐ Yes *(details)* _____	Date of return *(dd-Mon-yyyy)*	Relevant immunizations/dates

Consent

Contact Preference for COVID-19 Results:
☐ Text ☐ Automated Call ☐ Phone call from AHS
Phone number: _____

Health Care Worker? ☐ Yes ☐ No

Health Care Worker or Resident of **Long Term Care/Designated Supported Living** Facility?
☐ Yes ☐ No **If yes,** specify below ▼

Full Facility Name	**Location Code - Required** *(see link above for list of Codes)*	City or Town