

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

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

■ Consult the Site Microbiologist/Virologist-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		Date of Birth (dd-Mon-yyyy)		Expiry: _____	
	Legal Last Name			Legal First Name		Middle Name
	Alternate Identifier		Preferred Name		<input type="checkbox"/> Male <input type="checkbox"/> Non-binary	<input type="checkbox"/> Female <input type="checkbox"/> Prefer not to disclose
	Address		City/Town		Prov	Postal Code
Provider(s)	Authorizing Provider Name (last, first, middle)			Copy to Name (last, first, middle)		Copy to Name (last, first, middle)
	Address			Address		Address
	CC Provider ID	CC Submitter ID	Legacy ID	Phone		Phone
	Clinic Name			Clinic Name		Clinic Name
Collection	Date Collected (dd-Mon-yyyy)	Time (24 hr)	Location	Collector ID	Outbreak (EI) if applicable (yyyy-###)	

Specimen Source/Type

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

Specify Test *Check one as per clinical history.*

<input type="checkbox"/> COVID-19 only <input type="checkbox"/> COVID-19 and Influenza A/B (requires ILI symptoms) <input type="checkbox"/> COVID-19 and Respiratory Pathogen Panel (RPP) (requires ILI symptoms and RPP criteria)	Respiratory Pathogen Panel (RPP) Criteria <input type="checkbox"/> outbreak investigation (indicate EI# in "Outbreak [EI]" field above) <input type="checkbox"/> critical respiratory failure <input type="checkbox"/> severely immunocompromised (e.g. transplant, chemotherapy) <input type="checkbox"/> myocarditis/pericarditis <input type="checkbox"/> acute flaccid paralysis <input type="checkbox"/> pre-transplant
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Clinical History (required) *Choose all relating to reported symptoms.*

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)

<input type="checkbox"/> Outpatient or pending discharge <input type="checkbox"/> Hospital inpatient or pending admission <input type="checkbox"/> Close contact to a known COVID-19 case	Relevant travel history (include countries and dates of return) <input type="checkbox"/> No Travel Relevant immunizations (and dates)
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Health Care Work and Facility Information

Health Care Worker? Yes No
 Health Care Worker or Resident of LTC/DSL Facility? Yes No