COVID-19 Combined Referral and Lab Requisition Form

***Check Priority Group if Applicable ***

☐ 1. Person Under Investigation by Public Health

☐ 2. Symptomatic healthcare professional with direct patient care/contact (MD, NP, nurse, pharmacist etc.)

☐ 3. Symptomatic staff in hospitals, nursing homes, childcare centres and other institutional or group living settings with direct patient care/contact

☐ 4. Symptomatic patients/residents in institutional and group living settings with vulnerable populations (NH, corrections, shelter, etc.)

☐ 5. Hospitalized patients with respiratory symptoms (new or exacerbated) and no alternative laboratory-based diagnosis

☐ 6. Symptomatic members of Indigenous Communities

Referral Request Details

Name of individual completing form	**Phone number**	**Referral Date**

☐ 811	☐ Ambulance NB	☐ ICU
☐ Vitalité Zone 1 (Moncton)	☐ Horizon Zone 1 (Moncton)	☐ Hospital/ED
☐ Zone 4 (Edmundston)	☐ Zone 2 (Saint John)	☐ Clinic/CHC
☐ Zone 5 (Campbellton)	☐ Zone 3 (Fredericton)	☐ Correctional facility
☐ Zone 6 (Bathurst)	☐ Zone 7 (Miramichi)	☐ Nursing Home
☐ Public Health	☐ DH-Call Centre	☐ Other:
☐ EMP	☐ Provider Office	_____

Patient Information

Caller Name:	Relationship with Patient:	
Patient Last Name:	Patient First Name(s):	
Cell Phone or Phone: Email:	**Health Card Number (Medicare):** Include province if not NB, VAC, DND #	
Patient Address:	City:	Postal Code:
Primary Care Provider:	PCP Phone:	PCP Location:

Preferred Language ☐ English ☐ French ☐ Other

Sex ☐ Male ☐ Female

Pregnant? ☐ Yes ☐ No

Date of Birth: _____

Age: _____

Guardian Name if < 16 _____

Work Location of Healthcare Professional or Staff with symptoms:

☐ EM/ANB ☐ First Responder ☐ NH/LTC/ARF ☐ Physician Office ☐ Childcare centre ☐ Other _____

☐ Horizon ☐ Vitalité ☐ Hospital ☐ Lab ☐ Clinic ☐ Community Health Centre ☐ Community Pharmacy

Assessment Details

➢ **Test those meeting any two of the following symptoms:**

☐ Fever/chills ☐ Headache

☐ New onset/exacerbation of chronic cough ☐ Sore throat

☐ Coryza

Date symptoms started:_____

Collect risk factors, if applicable: ☐ Age 60+ ☐ Hypertension

☐ Cardio-vascular disease ☐ Chronic respiratory disease

☐ Diabetes ☐ Cancer ☐ Other_____

Additional Information:

Collect the following information, if applicable:

☐ Travelled outside of New Brunswick within past 14 days

Location: _____Return Date: _____

☐ Contact with confirmed case within past 14 days

☐ Close contact with a person with acute respiratory illness/group exposure in last 14 days

☐ Lab exposure to biological material (e.g. primary clinical specimens, virus culture isolates) known to contain COVID

Laboratory Requisition Additional Details

Sample source: ☐ Throat ☐ Nasopharyngeal ☐ Other

Collection Date (yyyy/mo/dd):	Time:
Collected by:	
Sentinel site: ☐ No ☐ Yes Specify: ☐ Admission ☐ ED	
Contact case: ☐ No ☐ Yes	Test of Cure: ☐ No ☐ Yes
Ordering Provider:	

[Place copy of specimen label here]

Label specimen as follows:

- **PHPR** - PH Priority Referral
- **HCP** - Direct Care Healthcare Professional
- **HCW** - Healthcare Worker/Staff
- **LTC/CORR/SHELTER/DAYCARE**
- **HOSP** - Hospitalized patient
- **INDIGENOUS** – Member from Indigenous community

Please submit community referrals for testing to the following fax number: 1-506-462-2040
Missing information should be added at specimen collection prior to submitting the requisition to the Lab