


Edmonton Site:  112 St. T6G 2J2
 Phone 780.407.7121 Fax 780.407.3864

 Calgary Site 3030 Hospital Dr NW T2N 4W4
 Phone 403.944.1200 Fax 403.270.2216

Virologist/Microbiologist-on-call 780.407.8822
Virologist/Microbiologist-on-call 403.944.1200

- 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 <i>(dd-Mon-yyyy)</i>		
	Legal Last Name		Legal First Name		Alternate Identifier
	Middle Name	Preferred Name	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X Non-binary/Prefer not to disclose		Phone
	Address		City/Town	Prov	Postal Code
Provider(s)	Authorizing Provider Name Dr. Yacoub, Wadieh Ramses		Copy to Name <i>(last, first, middle)</i>	Copy to Name <i>(last, first, middle)</i>	
	Address Canada Place, 730-9700 Jasper Ave NW, Edmonton		Phone 780-495-3391	Address	Address
	CC Provider ID 156831	Millennium ID 004699A	Sunquest ID A2806	Phone	Phone

Specimen/Type Source - Specify					
Date Collected <i>(dd-Mon-yyyy)</i>	Time <i>(24 hr)</i>	Location	Collector ID	Outbreak (EI) <i>if applicable (yyyy-####)</i>	
Specify Other Serology and Molecular Tests		Fluid		Swab	
<input type="checkbox"/> COVID-19 only <input type="checkbox"/> COVID-19/Respiratory Pathogen Panel		<input type="checkbox"/> Bronchoalveolar Lavage (BAL) <input type="checkbox"/> Nasopharyngeal Aspirate <input type="checkbox"/> Endotracheal Suction		<input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Throat	

Provide Clinical History or Reason for Testing below - Completion of this section is required			
Reason for Testing Investigation for COVID-19 exposure		List Countries visited within past 3 months of symptom onset OR provide relevant travel history	
Check ONE: <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic		<input type="checkbox"/> No Travel	
Date of onset of symptoms <i>(dd-Mon-yyyy)</i>		Date of return <i>(dd-Mon-yyyy)</i>	
Immunocompromised <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(details)</i> _____		Relevant immunizations/dates	

Consent
Contact Preference for COVID-19 Results:
<input type="checkbox"/> Text <input type="checkbox"/> Automated Dialer <input type="checkbox"/> Phone call from AHS
Phone number: _____