



Section 1 - Patient Information

PERSONAL HEALTH NUMBER (or out-of province Health Number and province)	DOB (DD/MMM/YYYY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK
PATIENT SURNAME	PATIENT FIRST AND MIDDLE NAME	
ADDRESS	CITY	POSTAL CODE

DATE RECEIVED

LABORATORY USE ONLY

OUTBREAK ID

Section 2 - Healthcare Provider Information

ORDERING PHYSICIAN (Provide MSC#) Name and address of report delivery	ADDITIONAL COPIES TO: (Address / MSC#) 1. 2. 3.
<input type="checkbox"/> I do not require a copy of the report	
CLINIC OR HOSPITAL Name and address of report delivery	
PHSA CLIENT NO.	

SAMPLE REF. NO.

DATE COLLECTED
(DD/MMM/YYYY)

TIME COLLECTED
(HH:MM)

Section 3 - Test(s) Requested

PATIENT STATUS <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> ER patient <input type="checkbox"/> History of contact with infection Travel history _____	SIGNS / SYMPTOMS Date of Onset: _____ (DD/MMM/YYYY) <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Cough <input type="checkbox"/> Fever <input type="checkbox"/> Rash <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Lower Respiratory Infection <input type="checkbox"/> Other, specify: _____	
RESPIRATORY VIRUSES <input type="checkbox"/> Nasopharyngeal swab <input type="checkbox"/> Nasal swab <input type="checkbox"/> Bronchoalveolar lavage <input type="checkbox"/> Nasal wash <input type="checkbox"/> Other, specify: _____ POC Tested Influenza A <input type="radio"/> Positive <input type="radio"/> Negative by Submitter: Influenza B <input type="radio"/> Positive <input type="radio"/> Negative RSV <input type="radio"/> Positive <input type="radio"/> Negative	HERPES VIRUSES <input type="checkbox"/> Genital lesion for HSV <input type="checkbox"/> Non-genital lesion for HSV <input type="checkbox"/> Skin swab for Varicella-Zoster <input type="checkbox"/> Other, specify: _____ Urine for: <input type="checkbox"/> Cytomegalovirus	GASTROINTESTINAL VIRUSES Feces* for: <input type="checkbox"/> GI Panel (Norovirus, Adenovirus, Astrovirus, Rotavirus, Sapovirus) <input type="checkbox"/> Other, specify: _____ *Guideline for Ordering Stool Specimens www.bcguidelines.ca/gpac/guideline_diarrhea.html
HEPATITIS VIRUSES EDTA Blood for: <input type="checkbox"/> HCV RNA Quantitative (Use for diagnosis and monitoring) <input type="checkbox"/> HCV Genotyping	ENCEPHALITIS / MENINGITIS Cerebrospinal Fluid for: <input type="checkbox"/> Encephalitis (e.g. HSV-1, West Nile Virus*) For WNV, specify travel to endemic area if not WNV season: _____ <input type="checkbox"/> Meningitis (HSV-2, Enterovirus) <small>*Offered during WNV season</small> <input type="checkbox"/> Other, specify: _____	MEASLES / MUMPS / RUBELLA VIRUSES <input type="checkbox"/> Measles <input type="checkbox"/> Rubella* <input type="checkbox"/> Urine <input type="checkbox"/> Nasal / Nasopharyngeal swab <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Mumps <input type="checkbox"/> Buccal swab <input type="checkbox"/> Urine <small>*Sample forwarded to reference laboratory for testing</small>
BIOPSY / AUTOPSY / OTHER TESTS <input type="checkbox"/> Specify: _____		

DATE INOC.			LABORATORY USE ONLY			
DATE	DAY	RMK	A549	MRC-5		

DATE INOC.		LABORATORY USE ONLY			
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