For PDF Fillable Requisitions, the following applies:

1. The form shall be completed using a Digital Health assigned computer.
2. Absolutely no personal health information shall be electronically saved on a computer.
3. The completed form shall not be shared electronically. If you reasonably believe that e-mailing the information is the only available method of communication or the only way to send the information then you must adhere to the Privacy guideline titled "E-mailing Personal Health Information".
4. All forms must be completed in their entirety, e.g. if a staff member has only completed half of a form they cannot save their work and then come back to complete it at a later date.
5. Once the personal health information has been recorded onto the form, it is to be printed immediately, deleted (not saved) from the computer, and then stored securely inside the client (paper) health record or scanned into an electronic record.
6. Do not print unnecessary duplicate copies of the form.
7. Regular audits of the Digital Health assigned computer shall be undertaken to ensure that no personal health information is being duplicated and saved.

ANTI-SARS-COV-2 ANTIBODY DETECTION REQUISITION

Lab Use Only:
Place Barcode Label Here

Acceptance Policy 10-50-03: Requirements for Test Requisitions 2.1 - Fields marked with * are mandatory and must be clearly legible or can result in specimen rejection.

ORDERING PROVIDER INFORMATION		**PATIENT INFORMATION** *(print or use addressograph)*
*Last & Full First Name:	Billing Code:	*Last/First Name: (per Health Card)
*Ordering Facility:		* Date of Birth (dd/mm/yyyy)
Address:		*Sex: □ Female □ Male □ Intersex
Phone Number:	Fax No:	*PHIN: Specify if other province/ DND)
Physician Signature:	Phone No.:	MRN:
COPY REPORT TO *(if info missing, report may not be sent):*		Encounter Number:
Last & Full First Name:	Fax No:	Patient Phone No:
Facility Name/ Address:	Phone No.:	Patient Address:
Last & Full First Name:	Fax No:	Demographics verified via: ❑ Health Card ❑ Armband ❑eChart/CR ❑ Other
Facility Name/ Address:	Phone No.:	

COLLECTION INFORMATION ***(Fields marked with ♦ required by person collecting sample)***		
♦ Collector:	♦ Collection Date:	♦Collected Via: ❑ Venipuncture ❑ Capillary ❑ Indwelling Line ❑ Above shut off IV
♦ Collection Facility/Lab:	♦ Time:	
# Serum vial(s) ____	# Plasma vials(p) ____	Referring Lab: # of tubes sent ____ Samples shipped frozen ❑

☐ Anti-SARS-CoV-2 Antibody Detection – Test Code: ACOV

Collect Li Heparin Plasma Separator tube(s) or Serum Separator (SST) tube(s) – Full Tube Collection

Provide:

Date of collection for COVID-19 PCR test: _____

If no PCR test, what test was used to make diagnosis: _____

Number of days of symptoms:_____

Testing will only to be performed if patient has had symptoms for < 9 days

Instructions for lab: Send sample as soon as possible to Chemistry Laboratory at Health Sciences Centre.
Sample must be transferred to an aliquot tube and stored frozen if analysis will not be complete within 48 hours.
Sample Stability: 14 days refrigerated, 3 months frozen. Send copy of requisition with sample to HSC.