Lambton Public Health

160 Exmouth Street
Sarnia, ON N7T 7Z6
Telephone: 519-383-8331
Toll free: 1-800-667-1839
www.lambtonpublichealth.ca

Referral Form for COVID-19 Testing Centre

Date _____ Primary Care Provider _____

Patient Name _____ DOB (DD/MM/YY _____

Phone (Home) _____ Phone (Mobile) _____

Address _____ City/Postal Code _____

Email _____ Occupation _____

Health Card Number _____

Individual meets the following COVID-19 Testing Criteria:

- ☐ Symptomatic contact of a confirmed case
- ☐ Symptomatic resident *living* in long-term care, retirement home or other congregate living or institutional setting: **NAME OF FACILITY**_____
- ☐ Symptomatic person *working* in long-term care, retirement home or other congregate living or institutional setting: **NAME OF FACILITY**_____
- ☐ Symptomatic health care worker / caregiver / care provider / first responder:

  NAME OF FACILITY / ORGANIZATION _____
- ☐ Symptomatic person living in same household of health care worker / caregiver / care provider / first responder: **SPECIFY** _____
- ☐ Symptomatic member of remote, isolated, rural and / or Indigenous communities
- ☐ OTHER (specific priority populations, essential workers, cross-border workers)
- ☐ Asymptomatic at time of referral

Referral Form completed by: _____ Referral Facility: _____

☐ **PATIENT INSTRUCTED TO MAINTAIN DAILY LOG OF SYMPTOMS**

☐ **PATIENT PROVIDED WITH SELF-ISOLATION INSTRUCTIONS:** *(https://www.publichealthontario.ca/en/diseases-and-conditions/infectious-diseases/respiratory-diseases/novel-coronavirus/public-resources)*

COVID-19 ASSESSMENT CENTRE SITES

Sarnia Site **Fax: 519-336-7894**	☐	**Petrolia Site** **Fax: 519-882-3003**	☐
Grand Bend Site **Fax: 1-855-946-1793**	☐		

Please fax to ONE SITE ONLY

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Date _____

Patient Name _____ **DOB (DD/MM/YY)** _____

Symptom Checklist:

☐ Fever (Temperature of 37.8°C or greater) Date of Onset_____

Any new or worsening symptoms:

☐ Cough Date of Onset_____
☐ Shortness of breath (dyspnea) Date of Onset_____
☐ Sore throat Date of Onset_____
☐ Runny nose or sneezing Date of Onset_____
☐ Nasal congestion Date of Onset_____
☐ Hoarse voice Date of Onset_____
☐ Difficulty swallowing Date of Onset_____
☐ New smell/taste disorder Date of Onset_____
☐ Nausea/vomiting Date of Onset_____
☐ Diarrhea Date of Onset_____
☐ Abdominal pain Date of Onset_____
☐ Clinical or radiological evidence of pneumonia Date of Onset_____
☐ Unexplained fatigue/malaise Date of Onset_____
☐ Delirium (acutely altered mental status and inattention) Date of Onset_____
☐ Falls Date of Onset_____
☐ Acute functional decline Date of Onset_____
☐ Exacerbation of chronic conditions: _____ Date of Onset_____
☐ Chills Date of Onset_____
☐ Headaches Date of Onset_____
☐ Croup Date of Onset_____
☐ Conjunctivitis _____ Date of Onset_____

Other Signs:

☐ Unexplained tachycardia Date of Onset_____
☐ Decrease in blood pressure Date of Onset_____
☐ Unexplained hypoxia (even if mild i.e. O2 sat <90%) Date of Onset_____
☐ Lethargy, difficulty feeding in infants (if no other diagnosis) Date of Onset_____