COVID-19 Referral Form

Patient Demographic Information	
Patient Name (Last, First)	
Gender	
Date of Birth	
Phone	
Health Card Number (Medicare)	
Address	
City	
Province	
Postal Code	
Primary Care Provider	
Primary Care Provider phone number	
Preferred Language	

Visit details	
Date received	
What is the nature of the visit	

Assessment Details		
Must present with ONE of the following:		**Must meet ONE of the following criteria:**
☐ Fever / chills ☐ New onset of (or exacerbation of chronic) cough	**AND**	☐ Travelled outside of Canada within past 14 days ☐ Contact with confirmed or probable case within the past 14 days ☐ Close contact with a person with acute respiratory illness who travelled outside of Canada in the last 14 days ☐ Had laboratory exposure to biological material (e.g. primary clinical specimens, virus culture isolates) known to contain COVID-19.

Travel Details	
Travel Destination	
Date left Canada	
Date Returned to Canada	
Date of Symptom onset	
If not travel related, was patient in contact with confirmed or probable case of COVID19	
Refer to following Assessment/Screening Centre	

Please submit the referral form to the COVID-19 Dispatch Center at the following fax number: (506) 462-2040

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