LABORATORY REQUEST FOR A PERSON SUSPECTED OF COVID-19 IN NUNAVIK

PRESCRIPTOR IDENTIFICATION	USER IDENTIFICATION
Name: First Name: Permit no. and function: Result Return Address: **Public Health Nunavik AND** ☐ **Inuulitsivik (IHC)** ☐ **Ungava Tulattavik (UTHC)** Doctor on call: **1-855-964-2244 or 1-819-299-2990** E-mail: surveillance.vigie.nrbhss@ssss.gouv.qc.ca covid_screening_result.RR17@ssss.gouv.qc.ca	File Number: Name: First Name: Date of birth: Sex: ☐ F ☐ M Health Insurance Number: Village: Postal Code: House No.: Tel.: E-mail: **User Health Region (CRGSS): 17-Nunavik** ☐ Not indicated ☐ Others _____
COLLECTED BY: _____ Date of sampling: _____ Time: _____ **Location of sampling (Village):** _____ Reception of sampling: Date: _____ Time: _____ (Laboratory)	
TYPE OF ANALYSIS ☐ ID NOW (**IHC: IDCOVI / UTHC: IDCOV**) ☐ PCR ☐ STANDARD **(IHC: PCRCOV / UTHC: COV19)** ☐ MULTIPLEX **(IHC: BILRESPI / UTHC: FLUVID)** (See: Screening Indications checklist and decision-making algorithm)	**SAMPLING SITE (CECH)** ☐ Throat / nose ☐ Nasopharyngeal ☐ Gargle ☐ Other: _____ ☐ Postmortem ☐ Not indicated
In the last 14 days (19VHQ) Travel outside Quebec: ☐ NO ☐ YES Country/Province **(19LDV)** _____ ☐ Not indicated	**SYMPTOMS COMPATIBLE WITH COVID (19SYM):** ☐ NO ☐ YES ☐ Not indicated
PRIORITIZED GROUPS M1 to M24 (19GRP) **INDICATIONS FOR SCREENING: M: _____** (See: Screening indications checklist and decision-making algorithm)	
Setting: Accommodation (19MHE) ☐ HC: Hospital Centre (All sectors) ☐ CH: Community Housing ☐ RH: (Sailivik, Elder's home, M-19) ☐ Long Term ☐ IR/FTR/RC ☐ Prison ☐ Other: _____ ☐ Not indicated ☐ Not applicable	**Setting: Health Care Worker (IHC: 19TRS / UTHC: 19MTS)** ☐ HC: Hospital Center ☐ RH ☐ Long Term ☐ IR/FTR/RC ☐ Laboratory ☐ CLSC ☐ Other: _____ ☐ Not indicated ☐ Not applicable **Setting: Work (19MTR)** ☐ Prison ☐ School ☐ Daycare ☐ Others: _____ ☐ Not indicated ☐ Not applicable

Signature: _____ Date: _____

((Name of authorized prescriber and collective prescription)

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ID NOW TEST

Public Health Contact Information	Name: _____
Doctor on call: 1 855 964-2244 or 1 819 299-2990 Result sent: surveillance.vigie.nrbhss@ssss.gouv.qc.ca AND to the IHC or UTHC laboratory Date: _____ Time: _____	First Name: _____ DOB: _____ File #: _____

PLACE OF TEST	
IHC	**CSTU**
☐ Kuujjuaraapik ☐ Umiujaq ☐ Inukjuak ☐ Puvirnituq ☐ Akulivik ☐ Ivujivik ☐ Salluit	☐ Kangiqsujuaq ☐ Quaqtaq ☐ Kangirsuk ☐ Aupaluk ☐ Tasiujaq ☐ Kangiqsualujjuaq ☐ Laboratory ☐ Elder's
☐ Traveler's Clinic ☐ Others: _____	

INITIAL RESULT	REDONE (IF REQUIRED)
AFFIX LABEL	AFFIX LABEL
RESULT	☐ INVALID ☐ Repeat test

Signature: _____ **Date:** _____

(Authorized person only)