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	
Does the patient meet the EVD compatible symptoms (Fever > 38C AND one or more of the symptoms listed below?	
Has the patient travelled outside of North America or had contact with a symptomatic traveler within the last 14 days	
Does the patient meet the COVID-19 case definition (see hint below)	
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 following fax number: (506) 462-2040

2020 03 16 V1