Brant Community Healthcare System

STARTING A NEW CHAPTER, **BE PART OF OUR STORY.**

Welcome TO BCHS!

WHAT YOU NEED TO DO BEFORE YOUR FIRST DAY:

- Review all content on the "New Hire Orientation" page on the BCHS website
- Complete all of the forms within this document
- Send a photo for your Identification Badge to Security via the form online

WHAT YOU NEED TO SUBMIT TO HUMAN RESOURCES BEFORE YOUR FIRST DAY:

1. Completed onboarding documents (this package)
2. Signed copy of your Employment Contract
3. Photocopy of social insurance number
4. Photocopy of one (1) piece of government issued photo ID
5. Direct deposit form or void cheque
6. Provincial & Federal Tax Forms
7. Letters of experience (if applicable)
8. Benefit enrollment forms (if applicable)

OTHER ITEMS TO SUBMIT WITHIN YOUR FIRST MONTH OF EMPLOYMENT:

1. Medical clearance documents *(must submit to Org Health within 14 days of employment)*
2. Book a pre-employment meeting with Organizational Health *(once ICT access is received)*

Onboarding Document as listed above must be completed and submitted to Human Resources within three (3) days of your start date. If we do not receive your paperwork there will be a delay in payroll processing.

Please send to hrforms@bchsys.org

BCHS CONFIDENTIALITY AGREEMENT

All employees/physicians/volunteers/students and staff from external agencies who have access to confidential information concerning patients, hospital personnel and hospital business are directed by the Brant Community Healthcare System Statement of Information Practices and are required to sign this Confidentiality Agreement, on an annual basis.

In my affiliation with Brant Community Healthcare System, I understand that:

- ☑ Brant Community Healthcare System has policies and procedures with respect to privacy, confidentiality, and security and it is my responsibility to be familiar with the requirements outlined in such policies and procedures.
- ☑ I will not use Brant Community Healthcare System information or communication systems to access confidential information unless legally authorized to do so and as required in the proper and faithful discharge of my duties or responsibilities
- ☑ Except when I am legally authorized to do so and as required in the proper and faithful discharge of my duties or responsibilities, I will not access, use or disclose confidential information that comes to my knowledge or possession by reason of my employment or affiliation with Brant Community Healthcare System.
- ☑ My handling of confidential information may be subject to monitoring and audit activities.
- ☑ I will not share my access codes (e.g. my computer password, voicemail password, pin number for door locks, pin for electronic signature).
- ☑ I have a responsibility to assist other persons employed or affiliated with Brant Community Healthcare System with their obligation to maintain confidentiality.
- ☑ I will not leave confidential information exposed for others to view (e.g. computer screen or patient record or discuss confidential information in public areas)
- ☑ I am required to report any breach or suspected breach of confidentiality to BCHS's Privacy Office; and
- ☑ I am accountable for my actions and the consequences of my actions related to the handling of confidential information.

Privacy breaches are subject to disciplinary action up to and including dismissal. Mandatory reporting to Regulatory Colleges is required for employees who are disciplined resulting from the unauthorized access, collection, use or disclosure of health information.

Attached to this document are questions and answers that will assist you with understanding the policy. One copy of this Agreement will be retained by BCHS to become part of your personnel file, and one copy will be given to you for your personal records.

I understand that a breach of this agreement may be cause for disciplinary action including, but not limited to, written warnings or letters of counsel, suspensions with or without pay, and/or immediate termination of employment, affiliation, suspension or revocation of hospital privileges with Brant Community Healthcare System; and prosecution under the law.

I also confirm that I have reviewed the confidentiality questions on answers on the next page of this document.

Print Name:	Signature:
Department:	Site (BGH/TWH):
Date:	Position:

CONFIDENTIALITY QUESTIONS & ANSWERS

Q. Yesterday you noticed that the wife of one of the doctor's had had a baby. Today, you meet someone from your department who asks, "What's new?" Is it all right for you to say quietly, "Dr. X's wife had a baby?" **No. The patient has the right to determine who should know she is a patient and any other details**

A. regarding her visit including good news like having a baby.

Q. Someone started working in your department a week ago and hasn't been for computer training yet. She needs to get some information from the computer. Should you sign onto the computer and help her out? **You may not sign on and walk away. You are responsible for all data entered under your password. It isokay to**

A. demonstrate or teach by having another person enter data under your direct supervision, but realize that you are responsible for that data as if you had entered it yourself.

Q. Someone you work with has been admitted to the hospital. Can you tell a co-worker just in case they wouldlike to visit this person?

A. No. That information is confidential unless the patient gives consent.

Q. Someone you work with has had blood work done. You are concerned about them and decide to check their lab results. You won't tell anyone else what you find out. Is this all right?

A. No. This information is confidential.

Q. You have been for an ultrasound about a suspicious lump. You have not been able to get in touch with your doctor and you are losing sleep because you are so worried. Are you allowed to look up information about yourself?

A. No. You must go through Health Records where proper procedures are followed in accordance with the legislation by which we are regulated.

Q. You work part-time and you have trouble remembering your computer password. Is it all right to put your password on a Post-It-Note on your computer terminal or write it on the back of your identification Badge?

A. No. Your password is confidential. It must be secure from access by anyone else. You are responsible forthe security of your password and all information that can be entered or viewed by using that password.

Q. You are working on a message in the Meditech system when you get called into your Director's office. Is itall right to leave your terminal while you are logged onto the system since you are only going to be away from your desk for a few minutes?

A. No. It only takes a moment for someone to view or enter data if you are still logged on.

Q. An elderly woman has been discharged from the hospital. Her son is requesting information from her charton behalf of his mother. Should the information be given to the son?

A. No. Not unless we have her consent.

Q. A friend of yours works at Siemens Electric Ltd. Your hospital is considering the purchase of some diagnostic equipment and this company is a possible vendor. The team has identified a preferred vendor.Your friend asks if his/her company is being considered. Can you tell him/her?

A. No. This information is confidential until the official announcement has been made.

Q. A police officer comes on to the unit, shows his/her identification and requests information about a patient?

A. No. Patient's consent is required for release of patient information. Although special conditions applywhen a warrant is presented and Administration should be consulted. (Exceptions: "Duty to Report" cases)

Print Name:	Signature:
Department:	Site (BGH/TWH):
Date:	Position:

HR INFORMATION PAGE 1/1

Please read all content on the website regarding new hire orientation before completing this document

1) MARKETING & CONSENT

☐ I agree to have my name mentioned in the hospital newsletter section regarding new staff
☐ I consent to having my picture or image used by the BCHS

2) POLICY AND PROCEDURE REVIEW

☐ I understand that it is my responsibility to be familiar with the requirements outlined in these policies and procedures. I understand that I can refer to my Manager or HR for the details of the policies. I understand that a breach of this agreement may result in disciplinary action, up to and including termination of my employment or affiliation with the BCHS.

3) REQUEST FORM – ACCESS AGREEMENT

☐ I have read the attached information and I understand that a breach of this agreement (access agreement) may result in disciplinary action, up to and including termination of my employment or affiliation with the BCHS.

4) CONFIDENTIALITY AGREEMENT

☐ I understand that a breach of this agreement may be cause for disciplinary action including, but not limited to, written warnings or letters of counsel, suspensions with or without pay, and/or immediate termination of employment, affiliation, suspension or revocation of hospital privileges with the BCHS; and prosecution under the law.
☐ I have read and signed the confidentiality agreement included in this onboarding package, and understand the content.

5) EXTRA HOURS OF WORK AGREEMENT

☐ I agree to accept these working conditions. By signing this agreement I understand that the agreement cannot be cancelled before the expiry date unless both the Employer and Employee agree to cancel it. I confirm that prior to signing this agreement**, I received from the BCHS, a document represented as the most recent Ministry of Labour Information Sheet.**
☐ N/A *(only select if you are a unionized employee)*

6) PHOTO IDENTIFICATION

☐ I understand that I must submit a copy of my Social Insurance Number (SIN) card and one (1) piece of government issued identification prior to my first day.
☐ I have submitted my Photo Identification for my ID Badge online

7) E-LEARNING

Within your first month of employment, you will be assigned mandatory e-learning courses. You will be required to complete by the due date assigned.

8) ☐ I have submitted all documentation verifying qualifications including registration, certification, diploma and degree requirements for current position as outlined by Recruiter upon offer.

I HAVE READ AND FULLY UNDERSTAND EACH ITEM LISTED ABOVE (#1 - #9)

_____	_____	_____
NAME	**SIGNATURE**	**DATE**

DIRECT DEPOSIT AUTHORIZATION

The Brant Community Healthcare System is hereby authorized and requested to credit payments due to me to my account with the financial institution designated below, until cancelled by myself in writing.

I, (print name) _____ hereby indemnify and save the Employer harmless from any claims, suits, judgements, attachments, and any form of liability, which may develop with the changing, cancelling and re-establishment of my bank account.

☐ **YES:** I have submitted a cheque marked "void" or an electronic funds transfer form (EFT-direct deposit form) with my onboarding paperwork. I have also confirmed that these documents are in my name.

50/50 DRAW & HOSPITAL FAMILY PROGRAM

☐ **YES:** I wish to take part in the BCHS 50/50 draw. I give permission to the BCHS to deduct $2.00 from each of my pay cheques. Should I wish to discontinue participation in this draw I may do so by notifying the Foundation or Payroll.
☐ **NO:** I do not wish to take part in the BCHS 50/50 draw.

☐ **YES:** I would like to join the Hospital Family Program and donate to the BCHS Foundation using payroll deduction. Please deduct _____ from each of my pay cheques. Please indicate what fund you would like your gift to benefit below:
☐ Unrestricted ☐ Top Priority Needs ☐ Equipment ☐ ED Redevelopment

PARKING

☐ **YES:** I request a monthly fee be deducted from the first pay of each month. It is understood that this arrangement may be cancelled by either party upon notice, at which time the card will be deactivated for parking.
☐ **NO:** I do not wish to sign up for Hospital parking at this time. I understand that should I wish to do so in the future, I must contact Security and/or the Business Cashier located within the hospital.

TAX FORMS

☐ **YES:** I have completed and submitted my Provincial Tax Forms
☐ **YES:** I have completed and submitted my Federal Tax Forms

EMERGENCY CONTACT

NAME:	**NAME:**
ADDRESS:	**ADDRESS:**
PHONE NUMBER(S):	**PHONE NUMBER(S):**
RELATION:	**RELATION:**

MARITAL STATUS

☐ **SINGLE** ☐ **MARRIED** ☐ **COMMON LAW**

_____ _____ _____
NAME **SIGNATURE** **DATE**

_____ _____
PAYROLL SIGNATURE **DATE**

1. HEALTHCARE OF ONTARIO PENSION PLAN (HOOPP):

PLEASE NOTE: Enrollment into the HOOPP pension plan is mandatory for Full-Time employees. If you are Casual, Part-Time, Job-Share or temporary, you MUST complete the section below.

☐ **YES:** I wish to enroll in HOOPP
☐ **NO:** I DO NOT wish to enroll in HOOPP
☐ I am a Regular Full-Time employee and understand that enrollment into the HOOPP pension plan is mandatory.

2. **REQUEST FOR EXPERIENCE PAY (ONA, SEIU, NON-UNION PARA/TECH) *** *If applicable, you MUST provide specific supporting documentation. Further information regarding what is required can be located here. In order to be considered for experience pay, your letter of experience must include: Position title, start date of employment, end date of employment, employment status and total hours worked. We are unable to accept experience letters unless they contain all of the required information. Please review the link and ensure you are providing all of the necessary documentation.*

☐ I hereby request consideration for previous recent and related experience and have provided the Hospital, in writing, verification of such.
☐ I have attached the required information in order to request experience pay.
☐ I will be submitting the required information in order to request experience pay once received from past employer.
☐ Not applicable. I will not be submitting a request for experience pay.

****Please note that SEIU Employees receive experience pay after serving their probation period****

3. **SUPERIOR CONDITIONS – EDUCATION (ONA MEMBERS ONLY) *** *if applicable, check the box of each that applies to you. You MUST provide supporting documentation. Please indicate which document you are attaching for each condition if checked off.*

☐ SPECIAL CLINICAL PREPARATION OF 6 MONTHS OR MORE: _____
(for example; 6 month certificates in the area of Perinatal, Psychiatry or Critical Care)

☐ A COURSE IN NURSING UNIT ADMINISTRATION: _____
(for example; Nursing Unit Administration traditionally refers to those responsible for the primary care of patients or oversees the work of others nurses. IE certificate or course in Nursing Leadership, Nursing Unit, Primary Care Nursing.

☐ A ONE YEAR UNIVERSITY CERTIFICATE IN DIPLOMA IN NURSING: _____
(for example; University Certificate in Hospital & Acute Care (2 Years))

☐ MASTER OF SCIENCE DEGREE IN NURSING

4. FOR FULL-TIME EMPLOYEES

☐ **YES**: I wish to be enrolled in the employee benefit program and have submitted my Green Shield Enrollment Form, indicating yes to the benefits I wish to be enrolled in.

☐ **NO:** I DO NOT wish to be enrolled in the employee benefit program and have submitted my Green Shield Enrollment Form, indicating no to the benefits I wish to be enrolled in.

☐ I have submitted the original signed Desjardins Enrollment form, indicating the beneficiary of my basic life insurance benefit.

☐ **GREEN SHIELD BENEFIT ENROLLMENT FORM** *(click HERE to open document)*

☐ **DESJARDINS ENROLLMENT FORM** *(click HERE to open document- please note you are only required to complete sections A, E & F)*

_____	_____	_____
NAME	**SIGNATURE**	**DATE**

BCHS Pre Employment/Placement Assessment and Review

One of the conditions of your employment with the Brant Community Healthcare System (BCHS) is having your Doctor complete a Pre-Employment Health Assessment form which our Occupational Health Nurse will review. The primary information required prior to employment is as follows:

- Current immunizations records, including TB, Rubella, Mumps, Measles, Varicella and Hepatitis B
- Your status related to Tetanus/Diphtheria/Pertussis and Influenza vaccinations
- 2 doses of covid-19 vaccination *(Watermarked vaccine receipt for must be provided and can be obtained at)* https://covid19.ontariohealth.ca

Please provide all of the immunization records and information directly to our Occupational Health Nurse by email or confidential Fax for review. Heather Jones, Heather.Jones@bchsys.org Fax: (519)751-5892

If the information is not readily available to you, a form is attached for you to take to your Doctor and to have it completed and returned to Organizational Health. The BCHS acknowledges that obtaining all required historical vaccination information in a timely manner may impact our ability to hire staff.

If you cannot get your physician to complete the Pre-Employment Health Assessment form and/or you cannot get any blood work completed to confirm your immunization records, then our Occupational Health Nurse will be able to assist with coordination of this information. If you require TB skin test or respirator fit test you can have this done by our Occupational Health Nurse during this appointment.

Every new employee must schedule a pre-employment appointment within 14 (fourteen) days after your corporate orientation date. All requested information should be sent prior to the appointment.

Click on the link for booking instructions: Appointment booking

Note that disclosure of any health issues does not automatically mean that the offer is rescinded. Any disclosures will be dealt with confidentially by the Occupational Health Nurse, taking into consideration the information disclosed and the position you have been offered.

Sincerely,

Erin Sleeth
Chief Human Resources Officer

Please acknowledge that you have read the above and agree to complete the pre-employment health assessment.

I _____ have read the information about the pre-employment health assessment. I understand that I have been hired for a position that puts me in contact with persons such as patients or staff who may or may not have been exposed to COVID19 and other communicable diseases. I understand that it is my responsibility to follow all policies and procedures on Personal Protective Equipment, hand-washing and other preventative measures such as vaccination and surveillance protocols.

I am aware that the Hospital has policies and procedures regarding the privacy, confidentiality, and security of my personal information. I understand it is my responsibility to be familiar with the requirements outlined in these policies and procedures. I understand I can refer to my Supervisor, Director or Chief Privacy Officer for the details of these policies and procedures.

First Name: _____ **Last Name: _____**
(please print)

Signature: _____ **Date (DD/MM/YYYY): _____**

On behalf of BCHS: *Erin Sleeth, Chief Human Resources Officer*

Employee Immunization Record

Name:_____ D.O.B_____
Phone:_____

Dear Healthcare provider: Your patient has applied to be an employee at the BCHS. To comply with the Public Hospitals Act, we must know the immunity status for Hepatitis B, Mumps, Measles, Rubella (German measles) and Varicella (chickenpox), of all persons carrying on activities in a hospital setting. Additionally, Medical directive #6 for public Hospitals requires that all Healthcare workers be vaccinated against COVID 19. Please complete this form, along with any follow up immunizations required and watermarked Proof of Covid-19 vaccination and provide it to your patient who is responsible to return it to Organizational Health at BCHS for clearance to start employment.

Proof of immunity needs to be returned to Organizational Health:

Fax# 5197515892 OR Email: heather.jones@bchsys.org drop off to Organizational Health E wing 4 floor

TUBERCULIN SKIN TESTING(Tb Skin Test)

2 Step TB Skintest (baseline -the second step needs to be completed within 30 days of the first step)

Date of Step 1: _____ Result: (pos/neg) _____ Induration _____mm
Date of Step 2: _____ Result: (pos/neg) _____ Induration _____mm

1 Step TB Skintest Date of Step 1: _____ Result: (pos/neg) _____ Induration _____mm

Hx of a Positive test: Chest x-ray Date: _____ Medically Cleared: (Y/N)_____

HEPATITIS B Vaccine Series and Titre

Date of Vaccination 1 _____
Date of Vaccination 2 _____
Date of Vaccination 3 _____

Results >10.00 mIU/ml indicate current or developing immunity

Surface Antibody Titre: _____ mIU/ml Immune Status:_____

MMR Measles, Mumps, Rubella

MEASLES: 2 MMR immunizations MMR #1 Date: _____ MMR #2 Date: _____
Laboratory Evidence of Immunity (Titre): Date: _____ Results :_____
MUMPS: 2 MMR immunizations MMR #1 Date: _____ MMR #2 Date: _____
Laboratory Evidence of Immunity (Titre): Date: _____ Results: :_____
RUBELLA: 2 MMR immunizations MMR #1 Date: _____ MMR #2 Date: _____
Laboratory Evidence of Immunity (Titre): Date: _____ Results :_____

VARICELLA one of the following is required

Varicella Vaccine (2 doses required): Vaccine #1 date: _____ Vaccine #2 Date: _____
Laboratory Evidence of Immunity (Titre): Date: _____ Results :_____

TETANUS/DIPTHERIA/PERTUSSIS

Vaccine given: _____ Date of last Immunization: _____

COVID VACCINE

Vaccine Brand given: _____ Date of 1st Immunization: _____
Vaccine Brand given: _____ Date of 2nd Immunization: _____
Watermarked vaccine receipt must be provided and can be obtained at https://covid19.ontariohealth.ca.

Exemption documentation provided _____

Respirator N 95

Manufacturer:_____Size:_____ Date Tested:_____

Healthcare Provider Information Name (print): _____
Signature of HCP: _____Date completed : _____

If you have any questions or concerns about the employee health review, please contact Organizational Health
Phone: 5197515544 ext. 2391 Confidential Fax: 5197515892 Email: heather.jones@bchsys.org

CONFIDENTIAL OCCUPATIONAL HEALTH REVIEW FORM

PERSONAL INFORMATION			
LAST NAME	FIRST NAME		MIDDLE INITIAL
DEPARTMENT	POSITION		
HEALTH CARD #	ADDRESS	CITY/TOWN	POSTAL CODE
PHONE NUMBER (☐ HOME | ☐CELL | ☐ WORK)	ALTERNATE PHONE (☐ HOME | ☐CELL | ☐ WORK)	DATE OF BIRTH (YYYY/MM/DD)	

EMERGENCY CONTACT	
NAME	PHONENUMBER (☐ HOME | ☐CELL | ☐ WORK)

HEALTH INFORMATION		
YES	NO	
☐	☐	Are you taking any regular prescription or non-prescription medication that may affect your abilities? If YES, Describe:
☐	☐	Is the skin on your hands intact? If NO, Describe:
☐	☐	Do you have any limitations that require modification of your job duties? If YES, Describe:
☐	☐	If YES to the previous question, are you under the care of a physician for the above condition?
☐	☐	Have you ever required adaptations or ergonomic changes to your work environment? If YES, Describe:
☐	☐	Do you smoke? If YES, for how long? How often?

HEALTH HISTORY (OPTIONAL)

Information contained is strictly confidential, and shall not be released to any source internally or externally without written consent of the employee named herein. Indicate with an X if you wish to discuss any of the following.

			Allergies:
☐ Abuse of Drugs or Alcohol	☐ Diabetes	☐ High Blood Pressure	☐ None
☐ Anemia	☐ Difficulty Breathing	☐ Immunosuppressive Disorder	☐ Food
☐ Anxiety	☐ Epilepsy	☐ Kidney/Urinary Problems	☐ Medication
☐ Arthritis/Joint Pain	☐ Eye Problem	☐ Loss of Hearing	☐ Latex
☐ Back Pain/Back Injury	☐ Fainting Spells/Dizziness	☐ Mental Illness	☐ Environment
☐ Cancer	☐ Foot Problems	☐ Pneumonia/Bronchitis/Asthma	☐ Seasonal
☐ Chest Pain/Tightness	☐ Frequent Head Aches/Migraines	☐ Other:	☐ Other:
☐ Chronic: Cough	☐ Heart Disease		
☐ Depression	☐ Hepatitis A, B, C		

LATEX ALLERGY SCREENING		
YES	NO	** IF YOU HAVE A LATEX ALLERGY, PLEASE PROVIDE DOCUMENTATION FROM YOUR HEALTH CARE PRACTITIONER **
☐	☐	Are you allergic to rubber, latex or powder in gloves?
☐	☐	Do you have reactions (swelling, itching, and trouble breathing/swallowing) during dental procedures?
☐	☐	Do your lips swell or itch after you blow up a balloon?
☐	☐	Have you had eczema or rashes on your hands?
☐	☐	Have you had rashes, hives or other reactions to wearing gloves or to powder in gloves?
☐	☐	Do you have food, drug, plant, or animal allergies? If YES, List:

WORK HISTORY

Have you ever been exposed to: ☐ Asbestos ☐ Ethylene Oxide ☐ Noise beyond acceptable limits ☐ Mercury ☐ Lead

YES	NO	
☐	☐	Have you ever received Workers' Compensation?
☐	☐	Have you ever had unprotected exposure to blood and body fluids? (e.g. needle sticks/blood or body fluid exposure)
☐	☐	Have you ever missed any time from work or sought medical care for a work related injury?
☐	☐	Have you ever missed any time from work or sought medical care for a work related illness?

To the best of my knowledge, the information on this form is current, complete, and accurate.

Employee Signature:

Date:

Public Health Ontario | Santé publique Ontario

Date received yyyy / mm / dd | PHOL No.

General Test Requisition

ALL Sections of this Form MUST be Completed

1 - Submitter

Courier Code

Provide Return Address:

Name
Address
City & Province
Postal Code

Clinician Initial / Surname and OHIP / CPSO Number
Dr. Elizabeth Thompson CPSO # 63283

Tel: 519-751-5544 Fax: 519-751-5892

2 - Patient Information

Health No. | Sex | Date of Birth: yyyy / mm / dd

Medical Record No.

Patient's Last Name *(per OHIP card)* | First Name *(per OHIP card)*

Patient Address

Postal Code | Patient Phone No.

Submitter Lab No.

Public Health Unit Outbreak No.

cc Doctor Information

Name: Dr. Elizabeth Thompson Tel:
Lab/Clinic Name: B.EHU/BCHS Fax: 519-751-5892
CPSO #: 63283
Address: 200Terrace Hill St Postal Code: N3R 1G9
Brantford ON

Public Health Investigator Information

Name:
Health Unit:
Tel: Fax:

3 - Test(s) Requested *(Please see descriptions on reverse)*

Test: Enter test descriptions below

Measles
Mumps
Rubella
Varicella

Hepatitis Serology

Reason for test (Check (✓) only one box):

- ☑ Immune status
- ☐ Acute infection
- ☐ Chronic infection

Indicate specific viruses (Check (✓) all that apply):

- ☐ Hepatitis A
- ☑ Hepatitis B
- ☐ Hepatitis C *(testing only available for acute or chronic infection; no test for determining immunity to HCV is currently available)*

4 - Specimen Type and Site

- ☑ blood / serum
- ☐ faeces
- ☐ nasopharyngeal
- ☐ sputum
- ☐ urine
- ☐ vaginal smear
- ☐ urethral
- ☐ cervix
- ☐ BAL
- ☐ other - *(specify)*

Patient Setting

- ☐ physician office/clinic
- ☐ ER (not admitted)
- ☐ inpatient (ward)
- ☐ inpatient (ICU)
- ☐ institution

5 - Reason for Test

- ☐ diagnostic
- ☑ immune status
- ☐ needle stick
- ☐ follow-up
- ☐ prenatal
- ☐ chronic condition
- ☐ immunocompromised
- ☐ post-mortem
- ☐ other - *(specify)*

Date Collected: yyyy / mm / dd

Onset Date: yyyy / mm / dd

Clinical Information

- ☐ fever
- ☐ gastroenteritis
- ☐ respiratory symptoms
- ☐ STI
- ☐ headache / stiff neck
- ☐ vesicular rash
- ☐ pregnant
- ☐ encephalitis / meningitis
- ☐ maculopapular rash
- ☐ jaundice
- ☐ other - *(specify)*
- ☐ influenza high risk - *(specify)*
- ☐ recent travel - *(specify location)*

For HIV, please use the HIV serology form. - For referred cultures, please use the reference bacteriology form.To re-order this test requisition contact your local Public Health Laboratory and ask for form number F-SD-SCG-1000. Current version of Public Health Laboratory requisitions are available at www.publichealthontario.ca/requisitions

The personal health information is collected under the authority of the Personal Health Information Protection Act, s.36 (1)(c)(iii) for the purpose of clinical laboratory testing. If you have questions about the collection of this personal health information please contact the PHOL Manager of Customer Service at 416-235-6556 or toll free 1-877-604-4567. F-SD-SCG-1000 (08/2013)

Ontario Agency for Health Protection and Promotion / Agence de protection et de promotion de la santé