

COVID-19 Publicly Funded PCR Testing Documentation Form for Pharmacies

Patient Name	Date/Time of Assessment
Healthcard No.	Gender
Date of Birth	Patient Phone No.
Patient Address	
Name of family physician/nurse practitioner (optional)	

Verbal patient/agent consent received for the assessment

Received by <small>(print name and signature)</small>	Date
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Patient Screening Completed ([COVID-19 Patient Screening Guidance Document](#))

COVID-19 Screening Result:

Positive

Negative

Unknown

Patient Assessment Questions:

1. Do you have the following symptoms that are new or worsening and are not chronic or related to other known causes or conditions#

At least one of the following:

- Fever and/or chills
- Cough
- Shortness of breath
- Decrease or loss of smell or taste

OR

Two or more of the following:

- Extreme fatigue, lethargy, or malaise
- Muscle aches or joint pain
- Nausea, vomiting and/or diarrhea
- Sore throat
- Runny nose/nasal congestion
- Headache

And belong to one of the following groups?

- Patient-facing healthcare workers
- Staff, volunteers, residents/inpatients, essential care providers, and visitors in highest risk settings which include: hospitals (including complex continuing care facilities and paramedic services) and congregate living settings, including Long-Term Care*, retirement homes, First Nation elder care lodges, group homes, shelters, hospices, and correctional institutions
- Household members of staff in highest risk settings† and patient-facing health care workers
- Temporary Foreign Workers in congregate living settings
- Patients seeking emergency medical care, at the discretion of the treating clinician
- Outpatients for whom COVID-19 treatment is being considered, including:
 - Immunocompromised individuals not expected to mount an adequate immune response to COVID-19 vaccination or SARS-CoV-2 infection, regardless of vaccination status.`
 - Individuals who are not fully vaccinated and at highest risk of severe disease (anyone aged ≥70 years or ≥60 years who is Indigenous and/or has additional risk factors)-
- People who are underhoused or homeless
- Pregnant people
- First responders, including fire, police and paramedics

If you received a COVID-19 vaccine in the last 48 hours and are experiencing mild fatigue, muscle aches, and/or joint pain that only began after vaccination, select "No".

Yes

No

2. Are you an elementary or secondary school student or education staff who is symptomatic and has received a PCR self-collection kit *through your school*?^

Yes

No

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3. Do you belong to one of the following groups?

- Individuals who are from a First Nation, Inuit, Métis community, and/or who self-identify as First Nation, Inuit, and Métis and their household members
- Individuals travelling into First Nation, Inuit, Métis communities for work
- People on admission/transfer to or from hospital or congregate living setting
- Close contacts and people in the context of confirmed or suspected outbreaks in highest risk settings[†] as directed by the local public health unit
- Individuals, and one accompanying caregiver, with written prior approval for out-of-country medical services from the General Manager, OHIP
- Asymptomatic testing in hospital, long-term care, retirement homes and other congregate living settings and institutions as per provincial guidance and/or Directives, or as directed by public health units

Yes

No

4. Are you seeking testing because it is 24–48 hours prior to your scheduled (non-urgent/emergent) surgical procedure requiring a general anaesthetic in a hospital or other surgical setting (e.g., independent health facility, etc.)?

Yes

No

5. Has your health care provider requested that you get tested before treatment or an appointment (i.e., hematopoietic cell therapy, cancer treatment, hemodialysis)?

Yes

No

Select one that applies:

If 'YES' to any of the questions numbered 1 to 5

Patient is **ELIGIBLE** for the Publicly-Funded COVID-19 Testing Services in Ontario Pharmacies program

If 'NO' to all of the questions numbered 1 to 5

 Patient is **INELIGIBLE** for the Publicly-Funded COVID-19 Testing Services in Ontario Pharmacies program

Additional notes (optional):

Pharmacist Name

OCP #

[#] Refer to the [COVID-19 Reference Document for Symptoms](#) for exceptions and more information.

^{*} It is mandatory to include the applicable Investigation Number on the test requisition forms for lab-based PCR testing for these individuals. Individuals should be reminded to provide the name of their long-term care home when booking and attending their appointment. Pharmacies must cross-reference the information provided with the lists of target settings provided by the Ministry of Health to confirm the individual's eligibility.

When completing the [requisition form](#), this information should be captured under the Patient Information (Section 2), in the field labelled: Investigation / Outbreak No. [Investigation Number Format: Can be any alphanumeric including dash (-) and underscore (_) up to a maximum of 15 characters.]

[†] Highest risk settings include hospitals (including complex continuing care facilities and paramedic services) and congregate living settings, including Long-Term Care, retirement homes, First Nation elder care lodges, group homes, shelters, hospices, and correctional institutions. All other settings would be considered non-highest risk.

[∨] For more information about immunocompromised individuals, please refer to the document on [COVID-19 Vaccine Third Dose Recommendations](#).

[~] Risk factors include obesity (BMI ≥30), dialysis or stage 5 kidney disease (eGFR <15 mL/min/1.73 m²), diabetes, cerebral palsy, intellectual disability of any severity, sickle cell disease, receiving active cancer treatment, solid organ or stem cell transplant recipients or other important risk factors at the opinion of the physician.

[^] The Investigation Number may already be included in the self-collection kits distributed by schools that are used by eligible individuals at home and subsequently dropped-off at the pharmacy. However, it is **NOT** mandatory for a pharmacy to record an Investigation Number for these individuals.

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Specimen Collection

Appropriate PPE donned according to guidelines, e.g.:

- A fit-tested, seal-checked N95 respirator (or approved equivalent); if not yet fit-tested for an N95 respirator a well-fitted surgical/procedure mask, a KN95 respirator or a non fit-tested N95 respirator (or equivalent) may be used
- Eye Protection (goggles, face shield or safety glasses with side protection)
- Gown
- Gloves

Option 1
In-Store Specimen Collection For
Lab-Based PCR Testing

- Verbal patient/agent informed
consent received for specimen
collection in pharmacy

Received by (pharmacist name)

Signature

OCP #

Date/Time of Specimen Collection

**Specimen Collected by (if different individual
from the above):**

Pharmacist Name

Signature

OCP #

Option 2
At-Home Patient Self-Collected
COVID-19 Specimen for Lab-Based
PCR Testing

- Self-Collection Kit Dispensed
 Self-Collection Kit Not Dispensed
(patient already has a kit)

Date/Time of Specimen Drop-Off

Specimen Received by:

Pharmacist Name

Signature

OCP #

- Quality Control Performed on Specimen

- Pass
 Asked Patient to Re-Test:

Reason

Option 3
In-Store Point-of-Care PCR Testing

- Verbal patient/agent informed
consent received for specimen
collection in pharmacy

Received by (pharmacist name)

Signature

OCP #

Date/Time of Specimen Collection

**Specimen Collected by (if different individual
from the above):**

Pharmacy Professional Name

Signature

OCP #

Results:

- Reported into MORE
 Disclosed to the PHU (if applicable)