

### List of Persons Being Tested for COVID-19

**Person Being Tested:** A term used in the CD Unit to define a person being tested for COVID-19, not meeting the provincial case definition of confirmed nor probable case, and does not have high-risk exposure to COVID-19. If contact tracing is indicated, complete Appendix 5 for each person tested and fax along with this form. Please fax completed list daily at end of day to the confidential CD fax line at: 807-343-5348. Faxing of the list is not required if there are no persons tested that day. Communities may use or adapt this template to report the information requested below.

Community Name: \_\_\_\_\_

Total tests today: \_\_\_\_\_

Date: \_\_\_\_\_

Faxed to CD Unit: Y / N

Demographic Information (If using sticker, ensure all information is provided below)	Date of swab	Symptoms –circle yes or no	Medical conditions – circle yes or no	Comments
Name of client: _____ Health Card Number: _____ DOB: _____ Address: _____ Gender: _____ Indigenous Heritage: <input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Metis <input type="checkbox"/> Other <input type="checkbox"/> Prefer to not disclose	YYYY / MMM / DD	Yes    No	Yes    No	
Name of client: _____ Health Card Number: _____ DOB: _____ Address: _____ Gender: _____ Indigenous Heritage: <input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Metis <input type="checkbox"/> Other <input type="checkbox"/> Prefer to not disclose	YYYY / MMM / DD	Yes    No	Yes    No	
Name of client: _____ Health Card Number: _____ DOB: _____ Address: _____ Gender: _____ Indigenous Heritage: <input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Metis <input type="checkbox"/> Other <input type="checkbox"/> Prefer to not disclose	YYYY / MMM / DD	Yes    No	Yes    No	
Name of client: _____ Health Card Number: _____ DOB: _____ Address: _____ Gender: _____ Indigenous Heritage: <input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Metis <input type="checkbox"/> Other <input type="checkbox"/> Prefer to not disclose	YYYY / MMM / DD	Yes    No	Yes    No	
Name of client: _____ Health Card Number: _____ DOB: _____ Address: _____ Gender: _____ Indigenous Heritage: <input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Metis <input type="checkbox"/> Other <input type="checkbox"/> Prefer to not disclose	YYYY / MMM / DD	Yes    No	Yes    No	
Name of client: _____ Health Card Number: _____ DOB: _____ Address: _____ Gender: _____ Indigenous Heritage: <input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Metis <input type="checkbox"/> Other <input type="checkbox"/> Prefer to not disclose	YYYY / MMM / DD	Yes    No	Yes    No	
Name of client: _____ Health Card Number: _____ DOB: _____ Address: _____ Gender: _____ Indigenous Heritage: <input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Metis <input type="checkbox"/> Other <input type="checkbox"/> Prefer to not disclose	YYYY / MMM / DD	Yes    No	Yes    No	