AVALON LABORATORIES BUILT ON TRUST	**Chain of Custody Form COVID-19 Asymptomatic Testing**	**Form:** CD-0001	**Approval:** PGA / DC
		Issue: Nov. 19, 2020 ***Rev. 9***	**Page:** 1 of 1

PLEASE WRITE CLEARLY TO ENSURE PROPER RESULT DELIVERY

Completed by Collector / Employer Representative

Ordering Medical Practitioner (Address + Phone No. – Mandatory)	Employer/Sample Information
	Employer Name:
	Employer Code:
	Swab Type: ☐ Nasopharyngeal ☐ ***Nasal*** + Oropharyngeal
X _____ Signature of Ordering Medical Practitioner	Media Type: ☐ Copan ***eNAT***

Patient Information

Patient Name: (Last, First)

MCP # / PHN # / Policy #: _____ (NL / Non-NL / INTL Residents) Date of Birth: ____ / ____ / ____ YYYY MONTH DD

Gender: ☐ Male ☐ Female ☐ Other Phone: _____ Address: _____

Email:

Collection Information

Collector Name: _____ ***Code:*** _____ Phone: _____

Collection Site Address: _____ ☐ NL collection site

_____ ☐ Outside NL collection site

Collection Date: _____ Collection Time: _____ AM / PM

I certify that I hold current valid certifications, licenses, and professional qualifications as required by the province to safely carry out swab collection for the test ordered above. The sample collected from the patient identified on this form was collected according to the instructions provided by Avalon Laboratories Inc. The sample was labeled, sealed, and stored appropriately until released to Avalon Laboratories Inc.

Collector Signature: _____ Date: _____

Completed by Patient

I certify that I provided this sample to the collector and that the information provided on this form and label is correct. I have read and signed the consent form for COVID-19 PCR testing. I understand that in some cases this test has been completed through the NL Public Health Laboratory. ***I understand that a copy of my report will be sent to my employer, if relevant.*** I understand that a positive result will be reported to the appropriate Medical Officer of Health ***(or delegate)*** for further investigation and that I may be contacted by them before receiving my test result from the laboratory.

Patient Signature: _____ Date: _____

Completed by Avalon Laboratories Inc.

Receiver: _____ Date: _____ Time: _____

If you have a question, concern, or complaint about how Avalon Laboratories collects, uses, or discloses your personal health information, please contact our COVID Coordinator by phone (below) or email: dryan@avalonlaboratories.ca.