

PHN		Accession #:		Microbiology Requisition		LABORATORY MEDICINE AND PATHOLOGY Client Response Centre (780) 407-7484 CAPITAL HEALTH REGION LABORATORIES DYNACARE KASPER MEDICAL LABORATORIES	
Patient Legal Name (Last)		(First)	(Initial)	DOB		<input checked="" type="checkbox"/> Copies to: Location: , , , <input type="checkbox"/> Fax Report Fax #	
Address						Bill Type CPL <input type="checkbox"/> Alberta Health Care OR	
Chart #	Patient Phone #	Lab #		Ordering Physician Physician Code _____ Specimen Event Type IP <input type="checkbox"/> IN PT OP <input type="checkbox"/> OUT PT AP <input type="checkbox"/> AMBUL HC <input type="checkbox"/> HMCARE ST <input type="checkbox"/> STAFF EN <input type="checkbox"/> ENVIRON		CO <input type="checkbox"/> Company OT <input type="checkbox"/> Out of Prov XX <input type="checkbox"/> Pre-Paid PB <input type="checkbox"/> Patient Bill Co. Name Address Client #	
Ordering Address		Report Location Code		<input type="checkbox"/> STAT Gram Stain (must provide phone number) ANTIBIOTICS? (Specify) <input type="checkbox"/> IN USE <input type="checkbox"/> FINISHED <input type="checkbox"/> PENDING			
Report Address if different							
Date specimen collected	Time (24 h)	*CLINICAL INFORMATION / HISTORY					
Collected by	Coll. Loc.						
BLOOD AND OTHER STERILE BODY FLUIDS				RESPIRATORY TRACT SPECIMENS			
BLDC <input type="checkbox"/> blood culture <input type="checkbox"/> aerobic <input type="checkbox"/> anaerobic <input type="checkbox"/> peds <input type="checkbox"/> peripheral <input type="checkbox"/> central site _____ CSFC <input type="checkbox"/> CSF culture <input type="checkbox"/> bone marrow culture <input type="checkbox"/> TB culture FLDC <input type="checkbox"/> fluid culture (specify) <input type="checkbox"/> viral culture <input type="checkbox"/> other _____				THRC <input type="checkbox"/> throat – routine culture ORAC <input type="checkbox"/> mouth culture (yeast only) NASC <input type="checkbox"/> nose culture (S. aureus carrier only) BPC <input type="checkbox"/> nasopharynx culture (for b. pertussis) (swab, suction, smear) <input type="checkbox"/> other (specify) _____ LOWER RESPIRATORY TRACT RESC <input type="checkbox"/> bacterial culture <input type="checkbox"/> sputum expectorated AFBC <input type="checkbox"/> mycobacterial culture(TB) <input type="checkbox"/> ETT suction <input type="checkbox"/> other _____ <input type="checkbox"/> bronchial wash (for BAL or PSB, use Bronch requisition)			
EYES AND EARS				URINARY TRACT SPECIMENS			
EYES <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> external eye (conjunctiva) EYEC <input type="checkbox"/> bacterial culture <input type="checkbox"/> cornea <input type="checkbox"/> Chlamydia trachomatis <input type="checkbox"/> other (specify) _____ <input type="checkbox"/> other (specify) _____ EARS <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> middle ear drainage/swab EARC <input type="checkbox"/> bacterial culture <input type="checkbox"/> external canal FUNC <input type="checkbox"/> fungal culture <input type="checkbox"/> T-tube in place <input type="checkbox"/> other (specify) _____ <input type="checkbox"/> recent surgery <i>*Relevant clinical history / therapy (give details above)</i>				URC <input type="checkbox"/> bacterial culture SPECIMEN <input type="checkbox"/> viral culture <input type="checkbox"/> MSU <input type="checkbox"/> other _____ <input type="checkbox"/> catheter – indwelling CLINICAL INFORMATION <input type="checkbox"/> catheter – intermittent <input type="checkbox"/> dysuria <input type="checkbox"/> recent GU surgery <input type="checkbox"/> cystoscopy <input type="checkbox"/> frequency <input type="checkbox"/> kidney transplant <input type="checkbox"/> other (specify) _____ <input type="checkbox"/> pyuria <input type="checkbox"/> other (specify) _____ <i>*Relevant clinical history / Antibiotic therapy (give details above)</i>			
GASTROINTESTINAL TRACT SPECIMENS				WOUNDS/SKIN/ABSCESES/SURGICAL SPECIMENS/TISSUES			
FECC <input checked="" type="checkbox"/> stool culture SPECIMEN CDT <input checked="" type="checkbox"/> Clostridium difficile toxin <input type="checkbox"/> feces OAP <input checked="" type="checkbox"/> ova and parasites* <input type="checkbox"/> other _____ PINW <input type="checkbox"/> pinworm examination <i>*Relevant clinical history and Travel (give details above)</i>				SITE (specify) _____ SPECIMEN <input type="checkbox"/> bacterial culture <input type="checkbox"/> swab FUNC <input type="checkbox"/> fungal culture / KOH <input type="checkbox"/> fluid <input type="checkbox"/> other _____ <input type="checkbox"/> tissue <input type="checkbox"/> skin scrapings CLINICAL INFORMATION <input type="checkbox"/> biopsy <input type="checkbox"/> abscess <input type="checkbox"/> deep ≥ 2 cm <input type="checkbox"/> bone chips <input type="checkbox"/> ulcer <input type="checkbox"/> superficial < 2 cm <input type="checkbox"/> IV catheter tips <input type="checkbox"/> wound <input type="checkbox"/> chronic infection <input type="checkbox"/> foreign body <input type="checkbox"/> surgical <input type="checkbox"/> compromised host _____ <input type="checkbox"/> trauma <input type="checkbox"/> other (specify) _____ <input type="checkbox"/> bite _____ <i>*Relevant clinical history / Antibiotic therapy (give details above)</i>			
GENITAL TRACT SPECIMENS				OTHER SPECIMENS/TESTS/SPECIAL REQUESTS			
VAGINA VAGC <input type="checkbox"/> bact. vaginosis / vaginitis (swab ± smear) WETM <input type="checkbox"/> Trichomonas vaginalis (swab) VAGC <input type="checkbox"/> culture for other organisms CERVIX GENC <input type="checkbox"/> GC culture <input type="checkbox"/> pregnant GENC <input type="checkbox"/> culture for other organisms <input type="checkbox"/> intra partum (clinical info required) <input type="checkbox"/> post partum <input type="checkbox"/> post surgical VAGINAL/RECTAL <input type="checkbox"/> PID STBC <input type="checkbox"/> group B strep screen <input type="checkbox"/> IUD in place (pregnant only) <input type="checkbox"/> STD <input type="checkbox"/> other _____ VULVA GENC <input type="checkbox"/> culture <input type="checkbox"/> H. ducreyl culture (submit in special TM) URETHRA DEG <input type="checkbox"/> smear GENC <input type="checkbox"/> GC culture GENC <input type="checkbox"/> culture for other organisms (clinical info required) PENIS (EXTERNAL) GENC <input type="checkbox"/> culture <input type="checkbox"/> H. ducreyl culture (submit in special TM) <i>*Relevant clinical history / antibiotic therapy (give details above)</i>				SITE (specify) _____ SPECIEN (type) _____ CHLC <input type="checkbox"/> Chlamydia trachomatis culture <input type="checkbox"/> viral culture <input type="checkbox"/> Chlamydia trachomatis antigen <input type="checkbox"/> H. simplex virus antigen <input type="checkbox"/> Chlam. pneumoniae culture (external genital lesions only) <input type="checkbox"/> Legionella culture <input type="checkbox"/> Buffy coat (CMV Ag) <input type="checkbox"/> Mycoplasma pneumoniae culture <input type="checkbox"/> Other test(s) <input type="checkbox"/> Genital mycoplasma culture (specify) _____			
				Laboratory Use Only			
				UC <input type="checkbox"/> urine collection Micro ACC # VP <input type="checkbox"/> venipuncture _____ NCL <input type="checkbox"/> not collected by lab			