

For PDF Fillable Requisitions, the following applies:

1. The form shall be completed using a Digital Health assigned computer.
2. Absolutely no personal health information shall be electronically saved on a computer.
3. The completed form shall not be shared electronically. If you reasonably believe that e-mailing the information is the only available method of communication or the only way to send the information then you must adhere to the Privacy guideline titled "E-mailing Personal Health Information".
4. All forms must be completed in their entirety, e.g. if a staff member has only completed half of a form they cannot save their work and then come back to complete it at a later date.
5. Once the personal health information has been recorded onto the form, it is to be printed immediately, deleted (not saved) from the computer, and then stored securely inside the client (paper) health record or scanned into an electronic record.
6. Do not print unnecessary duplicate copies of the form.
7. Regular audits of the Digital Health assigned computer shall be undertaken to ensure that no personal health information is being duplicated and saved.

# CLINICAL MICROBIOLOGY LABORATORY TEST REQUISITION

## ONE SPECIMEN PER REQUISITION

Lab use only  
IIS Barcode

Fields marked with \* are mandatory and must be clearly legible or can result in specimen rejection

<b>Ordering Provider Information</b>			<b>Patient Information</b> (print or use addressograph)		
*Last & Full First Name:		Billing Code:	*Last/First Name: (per Health Card)		
*Facility Name / Address:			* Date of Birth (dd/mm/yyyy)		
*Critical Results Ph #:		Fax #:	*Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		
Provider Signature:		Ph #:	*PHIN: Specify if other province/ DND		
<b>Copy Report To</b> (if info missing, report may not be sent):			MRN:		
Last & Full First Name:	Ph #:	Fax #:	Encounter#:		
			Patient Phone #:		
Facility Name/ Address:			Patient Address:		
Last & Full First Name:		Ph #:	Demographics verified via:		
Facility Name/ Address:		Fax #:	<input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other		
<b>Collection Information</b> (fields marked with ♦ required by person collecting sample)					
♦ Collector:	♦ Date Specimen Collected: _____ (DD) / _____ (MM) / _____ (YY)		♦ Time: _____ (24 h clock)		
<b>Diagnosis / Relevant Clinical Information</b>					
<input type="checkbox"/> Pregnant <input type="checkbox"/> Animal bite <input type="checkbox"/> Human bite <input type="checkbox"/> MRSA positive <input type="checkbox"/> Necrotizing fasciitis <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Bloody stool <input type="checkbox"/> Penicillin allergy					
Relevant Travel History? Location:			Diagnostic Information:		
<b>Blood Cultures</b> (two-site collection recommended for all patients >27kg. Includes routine bacteria and yeast; for other requests, contact the Microbiology Lab)			<b>Upper Respiratory Tract Specimens*</b>		
<input type="checkbox"/> Peripheral Draw – specify site: _____ <input type="checkbox"/> Central Venous/Arterial Catheter – specify site: _____			<input type="checkbox"/> Throat culture <input type="checkbox"/> Mouth culture (yeast only) <input type="checkbox"/> Nasal culture for <i>S. aureus</i> <input type="checkbox"/> Streptococcal antigen (rural sites only) <input type="checkbox"/> Pertussis PCR nasopharyngeal aspirate/swab <input type="checkbox"/> RSV antigen (nasopharyngeal aspirate/swab) – Churchill, Thompson only <b>*For molecular viral studies, please use Cadham Provincial Laboratory requisition</b>		
<b>Sterile Fluids</b>			<b>Lower Respiratory Tract Specimens</b>		
<input type="checkbox"/> CSF <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Fluid – site: _____ <input type="checkbox"/> Cryptococcal antigen (check one) <input type="checkbox"/> CSF <input type="checkbox"/> Blood		<b>Test:</b> <input type="checkbox"/> Bacterial culture – aerobic <input type="checkbox"/> Bacterial culture – anaerobic <input type="checkbox"/> Fungal culture <input type="checkbox"/> Mycobacterial culture (AFB)	<b>Specimen Type/Source:</b> <input type="checkbox"/> Sputum expectorated <input type="checkbox"/> Sputum induced <input type="checkbox"/> ETT suction <input type="checkbox"/> Bronchial wash <input type="checkbox"/> BAL		<b>Test:</b> <input type="checkbox"/> Bacterial culture – aerobic <input type="checkbox"/> Fungal culture <input type="checkbox"/> Mycobacterial culture (AFB) <input type="checkbox"/> Diagnostic <input type="checkbox"/> Follow-up <input type="checkbox"/> <i>Legionella</i> culture
<b>Eyes and Ears</b>			<b>Urinary Tract Specimens</b> Routine culture (bacteria & <i>Candida</i> spp.) will be performed only if clinical justification is provided.		
<b>Eyes:</b> <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Conjunctiva <input type="checkbox"/> Cornea <input type="checkbox"/> Vitreous fluid <b>Ears:</b> <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> External Canal <input type="checkbox"/> Middle ear/drainage fluid		<b>Test:</b> <input type="checkbox"/> Bacterial culture <input type="checkbox"/> Fungal culture <input type="checkbox"/> Acanthamoeba culture (eyes)			
<b>Antibiotic Resistant Organisms</b>			<b>Specimen</b>		
<b>MRSA</b> <input type="checkbox"/> Nose <input type="checkbox"/> Other (specify site): _____ <b>CPE</b> <input type="checkbox"/> Rectal <input type="checkbox"/> Other (specify site): _____			<b>Type/Source:</b> <input type="checkbox"/> MSU <input type="checkbox"/> Catheter <input type="checkbox"/> Other (specify): _____		<b>Clinical Justification:</b> <u>Symptomatic patient</u> <input type="checkbox"/> Lower UTI symptoms (e.g., urgency, frequency) <input type="checkbox"/> Suspected pyelonephritis <input type="checkbox"/> Sepsis <u>Asymptomatic patient/other</u> <input type="checkbox"/> Pregnant <input type="checkbox"/> Renal Transplant <input type="checkbox"/> GU Surgery <input type="checkbox"/> NICU
<b>Wounds/Skin/Abscesses/Surgical Specimens/Tissues</b>			<b>Test:</b>		
<b>Specify site:</b> _____ <input type="checkbox"/> Device – specify type: _____ <input type="checkbox"/> Orthopedic revision <b>Specimen Type/Source:</b> <input type="checkbox"/> Swab <input type="checkbox"/> Tissue/biopsy <input type="checkbox"/> Ulcer <input type="checkbox"/> IV catheter tips <input type="checkbox"/> Skin scrapings <input type="checkbox"/> Aspirate <input type="checkbox"/> Bone chips		<input type="checkbox"/> Bacterial culture – aerobic <input type="checkbox"/> Bacterial culture – anaerobic <input type="checkbox"/> Fungal culture <input type="checkbox"/> Mycobacterial culture (AFB)			
<b>Other Tests/Special Requests</b> *Contact lab to confirm availability or to obtain approval			<b>Gastrointestinal Tract Specimens</b>		
Specimen: _____ Specify Site: _____ Test(s) Specify: _____ Clinical information/test justification: _____			<input type="checkbox"/> Stool culture <input type="checkbox"/> Stool Mycobacterial culture (AFB) <input type="checkbox"/> <i>C. difficile</i> toxin <input type="checkbox"/> Pinworm (Westman Lab only) <input type="checkbox"/> <i>H. pylori</i> (biopsy culture) <input type="checkbox"/> Gastric Wash – Mycobacterial culture (AFB)		
*HSC 204.787.1273      * The Pas 204.623.6431 ext 30160 *SBH 204.237.2484      * Thompson 204.677.5304 ext 2216 *WL 204.578.4482			<b>Genital Tract Specimens</b>		
			<b>Vagina</b> (separate swab required for each test): <input type="checkbox"/> Bacterial vaginosis/Vaginal candidiasis (post-pubescent only) <input type="checkbox"/> <i>Trichomonas</i> <input type="checkbox"/> Culture (pre-pubescent only)		
			<b>Vaginal/Rectal:</b> <input type="checkbox"/> Group B <i>Streptococcus</i> screen (pregnant only) <b><i>N. gonorrhoeae</i> culture:</b> <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Other (specify site): _____ <b>Other genital specimen for culture:</b> <input type="checkbox"/> Vulva <input type="checkbox"/> Penis <input type="checkbox"/> Urethra <input type="checkbox"/> Labia <input type="checkbox"/> Bartholin cyst/abscess		