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
LIS Barcode

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

Ordering Provider Information

*Last & Full First Name: | Billing Code:

*Facility Name / Address:

*Critical Results Ph #: | Fax #:

Provider Signature: | Ph #:

Copy Report To *(if info missing, report may not be sent):*

Last & Full First Name: | Ph #: | Fax #:

Facility Name/ Address:

Last & Full First Name: | Ph #: | Fax #:

Facility Name/ Address:

Patient Information *(print or use addressograph)*

*Last/First Name: (per Health Card)

* Date of Birth (dd/mm/yyyy)

*Sex: □ Female □ Male

*PHIN: Specify if other province/ DND

MRN:

Encounter#:

Patient Phone #:

Patient Address:

Demographics verified via:
❑ Health Card ❑ Armband ❑eChart/CR ❑ Other

Collection Information *(fields marked with ♦ required by person collecting sample)*

♦ Collector: | ♦ Date Specimen Collected: _____ (DD) / _____ (MM) / _____ (YY) | ♦ Time: _____ (24 h clock)

Diagnosis / Relevant Clinical Information

❑Pregnant ❑ Animal bite ❑ Human bite ❑ MRSA positive ❑Necrotizing fasciitis ❑ Immunocompromised ❑Bloody stool ❑Penicillin allergy

Relevant Travel History? Location:

Diagnostic Information:

Blood Cultures *(two-site collection recommended for all patients >27kg. Includes routine bacteria and yeast; for other requests, contact the Microbiology Lab)*

❑ Peripheral Draw – *specify site*: _____
❑ Central Venous/Arterial Catheter – *specify site:* _____

Sterile Fluids

❑ CSF
❑ Bone Marrow
❑ Fluid – site: _____
❑ Cryptococcal antigen *(check one)*
❑ CSF ❑ Blood

Test:
❑ Bacterial culture – aerobic
❑ Bacterial culture – anaerobic
❑ Fungal culture
❑Mycobacterial culture (AFB)

Eyes and Ears

Eyes: ❑ Left ❑ Right
❑ Conjunctiva ❑Cornea
❑ Vitreous fluid
Ears: ❑ Left ❑ Right
❑ External Canal
❑ Middle ear/drainage fluid

Test:
❑Bacterial culture
❑Fungal culture
❑Acanthamoeba culture (eyes)

Antibiotic Resistant Organisms

MRSA ❑ Nose ❑ Other (*specify site*): _____
CPE ❑ Rectal ❑ Other (*specify site*): _____

Wounds/Skin/Abscesses/Surgical Specimens/Tissues

Specify site: _____
❑ Device – *specify type:* _____
❑ Orthopedic revision

Specimen Type/Source:
❑ Swab ❑ Tissue/biopsy
❑ Ulcer ❑ IV catheter tips
❑ Skin scrapings ❑ Aspirate
❑ Bone chips

Test:
❑ Bacterial culture – aerobic
❑ Bacterial culture – anaerobic
❑ Fungal culture
❑ Mycobacterial culture (AFB)

Other Tests/Special Requests **Contact lab to confirm availability or to obtain approval*

Specimen: _____ Specify Site: _____
Test(s) Specify: _____
Clinical information/test justification: _____

*HSC 204.787.1273
*SBH 204.237.2484
*WL 204.578.4482
* The Pas 204.623.6431 ext 30160
* Thompson 204.677.5304 ext 2216

Upper Respiratory Tract Specimens*

❑ Throat culture
❑ Mouth culture *(yeast only)*
❑ Nasal culture for *S. aureus*
❑ Streptococcal antigen *(rural sites only)*
❑ Pertussis PCR nasopharyngeal aspirate/swab
❑ RSV antigen (nasopharyngeal aspirate/swab) – Churchill, Thompson only
***For molecular viral studies, please use Cadham Provincial Laboratory requisition**

Lower Respiratory Tract Specimens

Specimen Type/Source:
❑ Sputum expectorated
❑ Sputum induced
❑ ETT suction
❑ Bronchial wash
❑ BAL

Test:
❑ Bacterial culture – aerobic
❑ Fungal culture
❑ Mycobacterial culture (AFB)
❑ Diagnostic ❑ Follow-up
❑ *Legionella* culture

Urinary Tract Specimens *Routine culture (bacteria & Candida spp.) will be performed only if clinical justification is provided.*

Specimen Type/Source:
❑ MSU
❑ Catheter
❑ Other *(specify):*

Clinical Justification:
Symptomatic patient
❑ Lower UTI symptoms *(e.g., urgency, frequency)*
❑ Suspected pyelonephritis
❑ Sepsis
Asymptomatic patient/other
❑ Pregnant ❑ Renal Transplant
❑ GU Surgery ❑ NICU

Test:
❑ Routine culture *(bacteria & Candida spp.)*
❑ *Legionella* antigen
❑ Other *(specify):*

Gastrointestinal Tract Specimens

❑ Stool culture
❑ *C. difficile* toxin
❑ *H. pylori* (biopsy culture)
❑ Stool Mycobacterial culture (AFB)
❑ Pinworm (Westman Lab only)
❑ Gastric Wash – Mycobacterial culture (AFB)

Genital Tract Specimens

Vagina *(separate swab required for each test):*
❑ Bacterial vaginosis/Vaginal candidiasis *(post-pubescent only)*
❑ *Trichomonas* ❑ Culture (*pre-pubescent only)*

Vaginal/Rectal: ❑ Group B *Streptococcus* screen (*pregnant only)*

***N. gonorrhoeae* culture:** ❑ Cervix ❑ Urethra ❑ Other (*specify site*): _____

Other genital specimen for culture: ❑ Vulva ❑ Penis ❑ Urethra ❑ Labia
❑ Bartholin cyst/abscess