DIAGNOSTIC SERVICES MANITOBA | SERVICES DIAGNOSTIC MANITOBA

CLINICAL MICROBIOLOGY LABORATORY TEST REQUISITION

St. Boniface Hospital
204-237-2484

LIS Barcode
Lab use only

*****PLEASE COMPLETE THE INFORMATION BELOW – PRINT CLEARLY*****

PHN/Health Care Number | Chart# | Visit#

☐M ☐F | Patient Legal Name (Last) (First) (Initial) | Birthdate DD MM YY

Outpatient Address | Outpatient Phone

Ordering Address/Location | Physician Code

Report Address if Different

Ordering Physician/Practitioner | Physician Critical Results Phone Number

☐ **Copy to**
Last Name _____
First Name _____
Facility Name _____
Address _____
Fax # _____
Full name, address & fax number MUST be provided

Date Specimen Collected DD MM YY | Time (24 h)

Collector

Diagnosis/Relevant Clinical Information:
☐UTI symptoms (any of; flank pain, frequency, dysuria) ☐Pregnant ☐Animal bite
☐Necrotizing fasciitis ☐Immunocompromised ☐Penicillin allergy ☐Human bite
☐MRSA positive

Diagnostic Information: _____

ONE SPECIMEN PER REQUISITION ONLY

Blood: *Two-site collection is recommended for all patients >27 Kg*

☐Blood culture ☐Peripheral draw Site (specify) _____
☐Central venous/arterial catheter
Site (specify) _____
☐Heterophile antibody (Mono test)

Sterile Fluids

☐CSF
☐Bone marrow
☐Fluid (site) _____
☐Cryptococcal Ag

Test:
☐Bacterial culture – aerobic
☐Bacterial culture – anaerobic
☐Yeast culture (e.g. *Candida*, *Cryptococcus*)
☐Moulds & systemic mycoses (e.g. *Aspergillus*, *Blastomyces*)
☐Mycobacterial culture (AFB)

Urinary Tract Specimens

Specimen
☐MSU/Catheter/Ileal Conduit
☐Suprapubic aspirate/Cystoscopy
☐Nephrostomy

Test:
☐Bacterial culture
☐*Legionella* antigen
☐Other (specify) _____

Eyes and Ears

Eyes ☐Left ☐Right
☐Conjunctiva ☐Cornea

Ears ☐Left ☐Right
☐External canal
☐Middle ear drainage/fluid

Test:
☐Bacterial culture – aerobic
☐Yeast culture (e.g. *Candida*, *Cryptococcus*)
☐Moulds & systemic mycoses (e.g. *Aspergillus*, *Blastomyces*)
☐Acanthamoeba culture

Antibiotic Resistant Organisms

MRSA
☐Nose
☐Other (specify site) _____

VRE
☐Rectal

Wounds/Skin/Abscesses/Surgical Specimens/Tissues

Specify site:
☐Swab
☐Tissue/Biopsy
☐IV catheter tips
☐Ulcer
☐Aspirate
☐Bone chips
☐Skin scrapings
☐Device (specify type) _____

Test:
☐Bacterial culture – aerobic
☐Bacterial culture – anaerobic
☐Yeast culture (e.g. *Candida*, *Cryptococcus*)
☐Moulds & systemic mycoses (e.g. *Aspergillus*, *Blastomyces*)
☐Mycobacterial culture (AFB)

Respiratory Tract Specimens

Upper Respiratory Tract
☐Throat culture
☐Mouth culture (yeast only)
☐Nasal culture for *S. aureus*
☐Pertussis PCR (nasopharyngeal aspirate/swab)

Lower Respiratory Tract
(Must indicate specimen/source)
☐Sputum expectorated
☐Sputum induced
☐ETT suction
☐Bronchial wash
☐BAL

Test:
☐Bacterial culture – aerobic
☐Yeast culture (e.g. *Candida*, *Cryptococcus*)
☐Moulds & systemic mycoses (e.g. *Aspergillus*, *Blastomyces*)
☐Mycobacterial culture (AFB)
☐**Diagnostic** ☐**Follow-up**
☐*Legionella* culture

Gastrointestinal Tract Specimens

☐Stool culture ☐*H. pylori* (biopsy culture)
☐*Clostridium difficile* toxin
☐Stool – Mycobacterial culture (AFB)
☐Gastric wash – Mycobacterial culture (AFB)

Genital Tract Specimens

Vagina (separate swab required for each test)
☐Bacterial vaginosis/Vaginal candidiasis (post-pubescent only)
☐*Trichomonas vaginalis*
☐Culture (prepubescent only)

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

***N. gonorrhoeae* culture**
☐Cervix ☐Urethra ☐Other Site (specify) _____

Other Genital Specimen for bacterial culture
☐Vulva ☐Penis ☐Urethra ☐Bartholin Cyst/Abscess
☐Labia

Other Tests/Special Requests

CONTACT MICROBIOLOGY LAB AT 204-237-2484 TO CONFIRM AVAILABILITY OR TO OBTAIN APPROVAL
Specimen _____
Specify site _____
Test(s) (specify) _____
Clinical information/Test justification _____

Instructions to Complete Clinical Microbiology Laboratory Test Requisition

PHN/Health Care Number **123456789**	Chart# **234567**	Visit# **3456789**	☐ **Copy to**
☒M ☐F	Patient Legal Name (Last) **Smith**	(First) **John**	(Initial)	Birthdate DD MM YY **26 11 1938**	Last Name
Outpatient Address **123 Main Street**		Outpatient Phone **204-555-1234**	First Name
Ordering Address/Location **A8PC**		Physician Code **0000**	Facility Name
			Address
			Fax #
			Full name, address & fax number MUST be provided
Report Address if Different			Date Specimen Collected DD MM YY **10 01 2010** / Time (24 h) **1430**
Ordering Physician/Practitioner **Dr. S. Jones**	Physician Critical Results Phone Number **204-555-6789**		Collector **S. Jones**

On The Requisition	
• Patient name (last name, first name)	• Name of Ordering Physician/practitioner
• PHIN # or Unique Identifier if PHIN unavailable (see below)*	• Collector (initials)
• Date of birth (DD/MM/YY)	• Collection date
• Gender	• Test requested
• Patient location (ward/clinic/nursing unit)	• Specimen type/source
On the Specimen Container	
• Patient name (last name, first name)	• Specimen type/source
• PHIN # or Unique Identifier	

***** Other unique identifiers include: Medical Records #, First Nation Inuit or Aboriginal Health # (10-digits), RCMP #, MHSC family number for newborn, Military #, inmate # if incarcerated, if not a Canadian state: "Private Patient", if test paid by Insurance Company state "Insurance Company Name", if immigrant state "immigration" as per DSM 100-50-4 and DSM 10-50-03.

If another physician requires a copy of the report, the **"Copy To"** section **must** be completed with the physician's full name, location (address), and fax number.

All information available in relation to the patient as outlined in this section must be entered. This information will be used by the laboratory to determine how the sample is processed. **Failure to provide such information may result in sub-optimal sample workup.**

Diagnosis/Relevant Clinical Information

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☐UTI symptoms (any of; flank pain, frequency, dysuria) ☐Pregnant ☐Animal bite
☐Necrotizing fasciitis ☐Immunocompromised ☐Penicillin allergy ☐Human bite
☐MRSA positive

Diagnostic Information: _____

Ordering Tests: Use one requisition per specimen only (unless multiple samples taken from the same source/site to provide sufficient specimen volume when multiple tests are ordered)

To order a test: Place an "X" in the box that describes the specimen being sent and the test being ordered.

Example #1:

Blood: *Two-site collection is recommended for all patients >27 Kg*

☒Blood culture ☒Peripheral draw Site (specify)**L. ACF**
☐Central venous/ arterial catheter Site (specify)

☐Heterophile antibody (Mono test)

Example #2:

Sterile Fluids

☐CSF
☐Bone marrow
☒Fluid (site)**L Knee**
☐Cryptococcal Ag

Test:
☒Bacterial culture – aerobic
☐Bacterial culture – anaerobic
☒Yeast culture (e.g. *Candida*, *Cryptococcus*)
☐Moulds & systemic mycoses (e.g. *Aspergillus*, *Blastomyces*)
☐Mycobacterial culture (AFB)

Microscopy and susceptibility tests are automatically done when appropriate; no need to order these on the requisition.

Note:

- **C&S is a term no longer used**. The term "Bacterial culture-aerobic" in the test request area on the requisition is synonymous with C&S.
- "Bacterial culture-anaerobic" is ***ONLY*** requested when the ordering physician is specifically suspecting anaerobic organisms. **Must supply relevant clinical information with this request. Requests without justification will be rejected for anaerobic culture.
- Swab samples from fluids or wounds are suboptimal. Always submit aspirates or tissues when possible.
- Tests done by Cadham Provincial Laboratory continue to require a Cadham Provincial Laboratory requisition. (Please refer to the CPL Laboratory Information Manual for completion of the CPL requisition.)
- Specimen collection practices (i.e., specimen source, specimen quality, specimen quantity) directly impact microscopy, culture, and molecular testing results generated by clinical microbiology laboratories for patients. Consult the online DSM Laboratory Information Manual (LIM) system (www.dsmanitoba.ca) for specific specimen collection guidelines. Additional information on specimen collection is available by phoning a DSM Clinical Microbiology Laboratory.