



# CLINICAL MICROBIOLOGY LABORATORY TEST REQUISITION

**Westman Laboratory**  
204-578-4482

LIS Barcode	Lab use only
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**\*\*\*PLEASE COMPLETE THE INFORMATION BELOW – PRINT CLEARLY\*\*\***

PHN/Health Care Number		Chart#		Visit#		<input type="checkbox"/> <b>Copy to</b>	
<input type="checkbox"/> M <input type="checkbox"/> F	Patient Legal Name (Last) (First) (Initial)		DD		Birthdate MM YY		Last Name First Name Facility Name Address Fax #
Outpatient Address				Outpatient Phone			
Ordering Address/Location				Physician Code			
Report Address if Different						Date Specimen Collected DD MM YY	
						Time (24 h)	
Ordering Physician/Practitioner			Ordering Physician/Practitioner Emergency Contact Number (For Critical Results)			Collector	
<b>Diagnosis/Relevant Clinical Information:</b>							
<input type="checkbox"/> UTI symptoms (any of: flank pain, frequency, dysuria)		<input type="checkbox"/> Pregnant		<input type="checkbox"/> Animal bite		<input type="checkbox"/> Human bite	
<input type="checkbox"/> Necrotizing fasciitis		<input type="checkbox"/> Immunocompromised		<input type="checkbox"/> Penicillin allergy			
<input type="checkbox"/> MRSA positive							
<b>Patient Location:</b> <input type="checkbox"/> Emergency <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> Personal Care Home <input type="checkbox"/> Outpatient							
<b>Diagnostic Information:</b>							

**ONE SPECIMEN PER REQUISITION ONLY**

<b>Blood:</b> Two-site collection is recommended for all patients >27 Kg		<b>Respiratory Tract Specimens</b>	
<input type="checkbox"/> Blood culture <input type="checkbox"/> Peripheral draw Site (specify) <input type="checkbox"/> Central venous/ arterial catheter Site (specify)		<b>Upper Respiratory Tract</b> <input type="checkbox"/> Throat culture <input type="checkbox"/> Streptococcal Ag <input type="checkbox"/> Mouth culture (yeast only) <input type="checkbox"/> Nasal culture for S. aureus <input type="checkbox"/> RSV (nasopharyngeal swab, aspirate) <input type="checkbox"/> Pertussis PCR (nasopharyngeal aspirate/swab)	
<b>Sterile Fluids</b>		<b>Lower Respiratory Tract</b>	
<input type="checkbox"/> CSF Test: <input type="checkbox"/> Bacterial culture – aerobic <input type="checkbox"/> Bone marrow <input type="checkbox"/> Bacterial culture – anaerobic <input type="checkbox"/> Fluid (site) <input type="checkbox"/> Yeast culture (e.g. Candida, Cryptococcus) <input type="checkbox"/> Moulds & systemic mycoses (e.g. Aspergillus, Blastomyces) <input type="checkbox"/> Mycobacterial culture (AFB) <input type="checkbox"/> Crystals (microscopy)		(Must indicate specimen/source) Test: <input type="checkbox"/> Sputum expectorated <input type="checkbox"/> Bacterial culture – aerobic <input type="checkbox"/> Sputum induced <input type="checkbox"/> Yeast culture (e.g. Candida, Cryptococcus) <input type="checkbox"/> ETT suction <input type="checkbox"/> Moulds & systemic mycoses (e.g. Aspergillus, Blastomyces) <input type="checkbox"/> Bronchial wash <input type="checkbox"/> Mycobacterial culture (AFB) <input type="checkbox"/> BAL <input type="checkbox"/> Diagnostic <input type="checkbox"/> Follow-up	
<b>Urinary Tract Specimens</b>		<b>Gastrointestinal Tract Specimens</b>	
Specimen Test: <input type="checkbox"/> MSU/Catheter/Ileal Conduit <input type="checkbox"/> Bacterial culture <input type="checkbox"/> Suprapubic aspirate/Cystoscopy <input type="checkbox"/> Legionella antigen <input type="checkbox"/> Nephrostomy <input type="checkbox"/> Other (specify)		<input type="checkbox"/> Stool culture <input type="checkbox"/> H. pylori (biopsy culture) <input type="checkbox"/> Clostridium difficile toxin <input type="checkbox"/> Pinworm <input type="checkbox"/> Stool – Mycobacterial culture (AFB) <input type="checkbox"/> Gastric wash – Mycobacterial culture (AFB)	
<b>Eyes and Ears</b>		<b>Genital Tract Specimens</b>	
Eyes <input type="checkbox"/> Left <input type="checkbox"/> Right Test: <input type="checkbox"/> Conjunctiva <input type="checkbox"/> Cornea <input type="checkbox"/> Bacterial culture – aerobic <input type="checkbox"/> Yeast culture (e.g. Candida, Cryptococcus) <input type="checkbox"/> Moulds & systemic mycoses (e.g. Aspergillus, Blastomyces) <input type="checkbox"/> Acanthamoeba culture		<b>Vagina (separate swab required for each test)</b> <input type="checkbox"/> Bacterial vaginosis/Vaginal candidiasis (post-pubescent only) <input type="checkbox"/> Trichomonas vaginalis <input type="checkbox"/> Culture (prepubescent only) <b>Vaginal/Rectal</b> <input type="checkbox"/> Group B Streptococcus screen (pregnant only) <input type="checkbox"/> N. gonorrhoeae culture <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Other Site (specify)	
<b>Antibiotic Resistant Organisms</b>		<b>Other Genital Specimen for bacterial culture</b>	
MRSA VRE <input type="checkbox"/> Nose <input type="checkbox"/> Rectal <input type="checkbox"/> Other (specify site)		<input type="checkbox"/> Vulva <input type="checkbox"/> Penis <input type="checkbox"/> Urethra <input type="checkbox"/> Bartholin Cyst/Abscess <input type="checkbox"/> Labia	
<b>Wounds/Skin/Abscesses/Surgical Specimens/Tissues</b>		<b>Other Tests/Special Requests</b>	
Specify site: <input type="checkbox"/> Swab Test: <input type="checkbox"/> Tissue/Biopsy <input type="checkbox"/> Bacterial culture – aerobic <input type="checkbox"/> IV catheter tips <input type="checkbox"/> Bacterial culture – anaerobic <input type="checkbox"/> Ulcer <input type="checkbox"/> Yeast culture (e.g. Candida, Cryptococcus) <input type="checkbox"/> Aspirate <input type="checkbox"/> Moulds & systemic mycoses (e.g. Aspergillus, Blastomyces) <input type="checkbox"/> Bone chips <input type="checkbox"/> Mycobacterial culture (AFB)		CONTACT MICROBIOLOGY LAB AT 204-578-4482 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 <b>123456789</b>		Chart# <b>234567</b>		Visit# <b>3456789</b>		<input type="checkbox"/> Copy to	
<input checked="" type="checkbox"/> M Patient Legal Name (Last) <b>Smith</b>		(First) <b>John</b>		(Initial)		Birthdate DD MM YY <b>26 11 1938</b>	
Outpatient Address <b>123 Main Street</b>				Outpatient Phone <b>204-555-1234</b>			
Ordering Address/Location <b>A8PC</b>				Physician Code <b>0000</b>			
Report Address if Different						Date Specimen Collected DD MM YY <b>10 01 2010</b>	
						Time (24 h) <b>1430</b>	
Ordering Physician/Practitioner <b>Dr. S. Jones</b>				Ordering Physician/Practitioner Emergency Contact Number <b>204-555-6789</b> (For Critical Result Communication)			
						Full name, address & fax number <b>MUST be provided</b>	
						Collector <b>S. Jones</b>	

### 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

**Diagnosis/Relevant Clinical Information:**

<input type="checkbox"/> UTI symptoms (any of; flank pain, frequency, dysuria)	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Animal bite
<input type="checkbox"/> Necrotizing fasciitis	<input type="checkbox"/> Immunocompromised	<input type="checkbox"/> Penicillin allergy
<input type="checkbox"/> MRSA positive	<input type="checkbox"/> VRE positive	<input type="checkbox"/> Human bite

**Patient Location:**  Emergency  Hospital inpatient  Personal Care Home  Outpatient

**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

<input checked="" type="checkbox"/> Blood culture	<input checked="" type="checkbox"/> Peripheral draw	Site (specify) L. ACF
	<input type="checkbox"/> Central venous/arterial catheter	Site (specify)

#### Example #2:

**Sterile Fluids**

<input type="checkbox"/> CSF	Test: <input checked="" type="checkbox"/> Bacterial culture – aerobic
<input type="checkbox"/> Bone marrow	<input type="checkbox"/> Bacterial culture – anaerobic
<input checked="" type="checkbox"/> Fluid (site) L Knee	<input checked="" type="checkbox"/> Yeast culture (e.g. Candida, Cryptococcus)
	<input type="checkbox"/> Moulds & systemic mycoses (e.g. Aspergillus, Blastomyces)
	<input type="checkbox"/> Mycobacterial culture (AFB)
	<input type="checkbox"/> Crystals (microscopy)

**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](http://www.dsmanitoba.ca)) for specific specimen collection guidelines. Additional information on specimen collection is available by phoning a DSM Clinical Microbiology Laboratory.