Western Health

MICROBIOLOGY REQUISITION

□ ROUTINE □ STAT □ OR

Form# 12-5005

The shaded fields are minimum required information from the ordering physician's office.

PATIENT INFORMATION	*ORDERING PRACTITIONER'S INFORMATION (PRINT FIRST AND LAST NAME LEGIBLY – OFFICE STAMP IS RECOMMENDED) **Locums must provide the usual provider's name and practice address**
*PATIENT'S NAME AS ON HEALTH CARE CARD	
*HEALTH CARE # (MCP OR OTHER INSURER)	
DATE OF BIRTH (DD/MM/YY) HEALTH CARD EXPIRY DATE (DD/MM/YY)	
DIAGNOSIS/RELEVANT HISTORY	*PRACTITIONER'S SIGNATURE * DATE OF REQUEST(DD/MM/YY)
	COPY TO PROVIDER

Current Medication	Date & Time of Last Dose	Antibiotic (specify):

BACTERIAL CULTURE (C & S)

Blood
- □ Peripheral
- □ Line/Port (specify) ____________________

□ **Peritoneal Dialysate**

CSF
- □ Drain
- □ Shunt
- □ Lumbar Puncture

Ear Left ____ Right ____
- □ Swab
- □ Aspirate

Eye Left ____ Right ____
- □ Direct Corneal Scrapings
- □ Swab
- □ Other (specify) ____________________

Fluid (specify) ____________________
- □ Needle Aspirate
- □ Drain
- □ Other (specify) ____________________

Genital
- □ Obstetrics Screen (Group B Strep)
- □ Vaginal Screen for Bacterial Vaginosis Trichomonas and Yeast
- □ Urethral
- □ Other (specify) ____________________

Gonorrhea Culture
- □ Cervix
- □ Urethral
- □ Other (specify)____________________

Chlamydia
- □ Cervical
- □ Vaginal
- □ Urine (Male/Female)

Oral Cavity
- □ Mouth
- □ Throat (Group A Strep)
- □ Other (specify) ____________________

Respiratory
- □ Bronchial Alveolar Lavage
- □ Bronchial Brush/Wash
- □ Sputum
- □ Tracheal Aspirate
- □ Other (specify) ____________________

Stool
- □ Rotavirus
- □ Norwalk
- □ Occult Blood
- □ Culture (use enteric transport)
- □ C. difficile (sterile container)
- □ Ova & Parasites
- □ Fecal WBC's

Urine
- □ Catheter (specify) ____________________
- □ Midstream
- □ Pregnancy Test
- □ Other (specify) ____________________

Urine from O.R.
- □ Cystoscopic
- □ Nephrostomy (aspirate)
- □ Suprapubic (aspirate)
- □ Other (specify)____________________

Wound (specify source)____________________
- □ Dental abscess
- □ Tissue
- □ Catheter tip
- □ Swab

TB Culture
- □ Specify Source ____________________

SPECIFIC ORGANISM REQUESTS

- □ MRSA Screen (site) ________________
- □ VRE Screen (site) ________________
- □ Other (organism) ________________
- □ Nose (for MSSA/MRSA only)

FUNGAL CULTURE

Specimen (specify) ____________________
- □ Fungus
- □ Yeast
- □ Dermatophyte: Hair Nails Skin
- □ Pneumocystis Jiroveci (carinii)

EPIDEMIOLOGY

- □ Herpes Simplex Virus (Specify) ____________________
- □ Respiratory Virus Nasopharyngeal
- □ Bordetella Pertussis Nasopharyngeal

OTHER MICROBIOLOGY REQUESTS

Specify specimen type, test, and provide history

DATE & TIME OF COLLECTION: ____ *INITIALS:* ____________________

Revised March 24, 2016