MICROBIOLOGY REQUISITION

☐ Routine ☐ STAT

PLEASE REFER TO LABORATORY TEST INFORMATION GUIDE

REFERRING PHYSICIAN

Ordering Physician:

Collected by:

Date & Time Collected:

☐ Inpatient ☐ Outpatient ☐ Pre-op

☐ STAT Phone results to:

Name Ext # Pager #

Relevant Clinical Information:

PATIENT INFORMATION

PIN: Unit: Room #:

Health Card #:

Last Name:

First Name:

Date of Birth:

Sex: M ◯ F ◯ Other ◯

Physician:

Copy To:

Unit/Clinic: Tel/Ext:

SPECIMEN TYPE

Specimen Description: Body Site:

BACTERIAL CULTURE (C & S)

Blood
- ☐ Peripheral
- ☐ Line/Port (specify): _____
- ☐ Tip (specify): _____

☐ **CAPD/Peritoneal Dialysate**

CSF
- ☐ Drain ☐ Shunt ☐ Lumbar Puncture
- ☐ Tip/Device (specify): _____

☐ **Ear** (specify): _____

Eye
- ☐ Direct Corneal Scrapings (use eye kit)
- ☐ Swab ☐ Other (specify): _____

Fluid
- ☐ Vitreous fluid or Aqueous humour
- ☐ Synovial fluid ☐ Fluid - orthopedic
- ☐ Pleural fluid ☐ Peritoneal fluid
- ☐ Drainage ☐ Aspirate
- ☐ Aspirate vital organ

Genital
- ☐ Obstectrics Screen *(Group B Strep)*
- ☐ Vaginal Screen for Bacterial Vaginosis, Trichomonas and Yeast
- ☐ Urethral
- ☐ Other (specify): _____

Gonorrhoeae Culture
- ☐ Cervix ☐ Urethral ☐ Other (specify): _____

Oral Cavity
- ☐ Mouth ☐ Thoat ☐ Other (specify): _____

Respiratory
- ☐ Bronchoalveolar Lavage
- ☐ Bronchial Brush/Wash
- ☐ Sputum ☐ Tracheal Aspirate
- ☐ Other (specify): _____

Cystic Fibrosis Respiratory
- ☐ Throat ☐ Tracheal Aspirate ☐ Sputum

Bronchiectasis Respiratory
- ☐ Sputum ☐ Tracheal Aspirate

Stool
- ☐ Culture
- ☐ C.difficile
- ☐ Ova and Parasites

☐ **Tissue/Biopsy** (specify): _____

☐ **Tissue Bank** (please provide all info): _____

Urine
- ☐ Catheter (indwelling): _____
- ☐ Catheter (In/Out)
- ☐ Midstream
- ☐ Nephrostomy Drainage
- ☐ Other (specify): _____

Urine from O.R.
- ☐ Cystoscopic ☐ Nephrostomy (aspirate)
- ☐ Suprapubic (aspirate)
- ☐ Other (specify): _____

Wound Swab
- ☐ Abscess / cyst superficial ☐ Ulcer
- ☐ Burn/graft ☐ Bite
- ☐ Wound orthopedic
- ☐ Wound deep
- ☐ Wound deep - Vital organ

SPECIFIC ORGANISM REQUESTS
- ☐ MRSA Screen (site): _____
- ☐ VRE Screen (site): _____
- ☐ ESBL Screen (site): _____
- ☐ CPE Screen (site): _____

FUNGAL CULTURE
Specimen (specify): _____
- ☐ Fungus
- ☐ Yeast
- ☐ Dematophyte:
  - ◯ Hair ◯ Nails ◯ Skin
- ☐ Pneumocystis carinii - (Pneumocystis jiroveci)

EPIDEMIOLOGY
Source of Sample: _____

Comments: _____
- ☐ Air Culture
- ☐ Bacterial Endotoxin (Limulus)
- ☐ Colony Count
- ☐ Sterility Check
- ☐ Other (specify): _____

OTHER MICROBIOLOGY REQUESTS
(Please provide all required requisitions for tests)

Specify specimen type, test, and provide history:

MICROBIOLOGY LABORATORY
Victoria Hospital, Room #B10-210
800 Commissioners Road East
London, Ontario | N6A 5W9
Ph: 519-685-8500, ext #58212 | Fax: 519-685-8360

London Health Sciences Centre

St. JOSEPH's HEALTH CARE LONDON

Pathology and Laboratory Medicine

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