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 #: **204-957-0884**

WRHA TB Services

Facility Name/ Address:

2-496 Hargrave St. Winnipeg, MB

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