

**LONDON HEALTH SCIENCES CENTRE
MICROBIOLOGY REQUISITION**

Routine **STAT** O.R.

Ordering Physician: _____

Collected By: _____

Date (YYYY/MM/DD) & Time Collected: _____

Inpatient Outpatient Pre-op

PLEASE PRINT AND COMPLETE IN FULL.

ACCESSION NUMBER

PIN: _____ UNIT: _____ ROOM #: _____

NAME: _____ Last First

ADDRESS: _____

SEX: _____ BIRTHDATE: _____ YYYY/MM/DD AGE: _____

OHC#: _____

PHYSICIAN: _____

COPY TO:
NAME (PLEASE PRINT): _____

UNIT/CLINIC: _____ TEL/EXT: _____

ADDRESSOGRAPH LABEL HERE

Relevant Clinical Information: _____

STAT Phone results to:

_____ (NAME) _____ (EXT) _____ (PAGER)

Specimen Description: _____

Body Site: _____

BACTERIAL CULTURE (C & S)

Anaerobic Culture (must be in Anaerobic Transport) (specify): _____

Blood

Peripheral
 Line/Port (specify): _____
 Tip (specify): _____

CAPD/Peritoneal Dialysate

CSF

Drain
 Shunt
 Lumbar Puncture
 Tip (specify): _____

Ear (specify): _____

Eye

Direct Corneal Scrapings (use eye kit)
 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): _____

Gonorrhoeae Culture

Cervix
 Urethral
 Other (specify): _____

Antigen Detection for *N. gonorrhoeae* and *Chlamydia* (requires Public Health Requisition)

Mycobacterium / AFB / TB (requires Public Health Requisition) (specify): _____

Oral Cavity

Mouth
 Throat (*Group A Strep*)
 Other (specify): _____

Respiratory

Bronchial Alveolar Lavage
 Bronchial Brush/Wash
 Sputum
 Tracheal Aspirate
 Other (specify): _____

Cystic Fibrosis Respiratory

Throat
 Tracheal Swab/Aspirate
 Sputum

Stool

Culture (use enteric transport)
 C.difficile (sterile container)
 Ova & Parasites (use parasitology kit)
 History/Travel (specify): _____

Tissue/Biopsy (specify): _____

Tissue Bank (please provide all information): _____

Urine

Catheter (specify): _____
 Midstream
 Other (specify): _____

Urine from O.R.

Cystoscopic
 Nephrostomy (aspirate)
 Suprapubic (aspirate)
 Other (specify): _____

Wound Swab (specify): _____

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

Relevant Clinical Data: _____

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:

PLEASE REFER TO THE LABORATORY TEST GUIDE (http://www.lhsc.on.ca/cgibin/view_labtest.pl)