



Eastern Health

Laboratory Medicine

Public Health and Microbiology Specimen Collection Requisition

For outpatients or internal during meditech downtime.



CL2100 1854 03 2018

Name: _____ HCN: _____ Date of Birth: <u>DD/MONTH/YYYY</u> Age: _____ Sex: _____ Unit/Ward: _____ Address: _____	Physician Information (please use stamp) Physician's Signature: _____ Physician's Mnemonic: _____ Date of Request: <u>DD/MONTH/YYYY</u> Telephone Number: _____
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Diagnosis: _____ Immunocompromised? Yes No

Antibiotics in use: _____

Travel History: _____

Type of Specimen: Please check appropriate box(es)

Sterile Body Fluids <input type="checkbox"/> Blood (Specify site) _____ <input type="checkbox"/> Fluid (Specify site) _____ <input type="checkbox"/> Serum <input type="checkbox"/> Plasma	Respiratory <input type="checkbox"/> Expectorated Sputum <input type="checkbox"/> Tracheal Aspirate (intubated) <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> Throat Swab <input type="checkbox"/> Nasal Swab (C&S) <input type="checkbox"/> Nasopharyngeal Swab (PCR)	Collected by invasive method? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Stool (Include duration of diarrhea) _____ <input type="checkbox"/> Wound Site: _____ <input type="checkbox"/> Tissue Site: _____
Urine <input type="checkbox"/> Clean Catch (Midstream) <input type="checkbox"/> In\Out Catheter <input type="checkbox"/> Indwelling Catheter <input type="checkbox"/> Suprapubic Catheter <input type="checkbox"/> Cystoscopy	Urogenital <input type="checkbox"/> Urethral swab <input type="checkbox"/> Cervical Swab <input type="checkbox"/> Vaginal Swab <input type="checkbox"/> Vaginal/Rectal (Group B Strep)	Other samples / Comments _____ _____

Test Requested:

<input type="checkbox"/> C&S	<input type="checkbox"/> TB Culture	<input type="checkbox"/> O&P	<input type="checkbox"/> Fungus
<input type="checkbox"/> HIV Screen	<input type="checkbox"/> Syphilis Screen	<input type="checkbox"/> CT/NG Testing (Swab)	<input type="checkbox"/> CT/NG Testing (Urine)
<input type="checkbox"/> Hepatitis Diagnosis Panel	<input type="checkbox"/> Hep B Immunity Screen	<input type="checkbox"/> Respiratory Panel	
<input type="checkbox"/> Virus (specify) _____		<input type="checkbox"/> Other (specify) _____	

Collected by:

Name: _____ Signature: _____

Date and Time of Collection: DD/MONTH/YYYY

Lab Specimen Number (Lab use only): _____