BC Centre for Disease Control
An agency of the Provincial Health Services Authority

Public Health Laboratory

655 West 12th Avenue, Vancouver, BC V5Z 4R4
www.bccdc.ca/publichealthlab

Bacteriology & Mycology Requisition

LM LABS

Section 1 - Patient Information

PERSONAL HEALTH NUMBER (or out-of province Health Number and province)	**DOB** (DD/MMM/YYYY)	**GENDER** ☐ M ☐ F ☐ UNK
PATIENT SURNAME	**PATIENT FIRST AND MIDDLE NAME**	
ADDRESS	**CITY**	**POSTAL CODE**

DATE RECEIVED

LABORATORY USE ONLY

OUTBREAK ID

SAMPLE REF. NO.

DATE COLLECTED (DD/MMM/YYYY)

TIME COLLECTED (HH:MM)

Section 2 - Healthcare Provider Information

ORDERING PHYSICIAN (Provide MSC#)
Name and address of report delivery

☐ **I do not require a copy of the report**

CLINIC OR HOSPITAL
Name and address of report delivery

PHSA CLIENT NO.

ADDITIONAL COPIES TO: (Address / MSC#)

1.

2.

3.

Section 3 - Test(s) Requested

USE REVERSE SIDE TO SUBMIT ISOLATES FOR IDENTIFICATION AND/OR TYPING

SEXUALLY TRANSMITTED INFECTIONS

Source	Test Requests: Chlamydia & Gonorrhea NAT	LGV	Gonorrhea Culture	Trichomonas NAT	Direct Smears
Cervix	☐		☐	☐	
Vagina	☐		No cervix ☐	☐	Bacterial vaginosis & yeast ☐
Urethra	☐		☐		Gonorrhea & pus cells ☐
Urine	☐			Female only ☐	
Rectal	☐		☐		
Lesion ☐ Genital ☐ Rectal	☐	☐	☐		
Throat	☐		☐		
Eye	Dry swab ☐		☐		Gonorrhea ☐
Nasopharyngeal aspirate or swab (neonates only)	Chlamydia DFA ☐				
Tracheobronchial aspirate	Chlamydia DFA ☐				

MYCOLOGY

☐ Sputum
☐ Bronchial wash
☐ Body fluid, specify: _____
☐ Tissue / Biopsy / Abscess, specify: _____
☐ Other, specify: _____

TRAVEL: ☐ YES, specify: _____ ☐ NO

CLINICAL INFORMATION: _____

RESPIRATORY INFECTIONS

Pertussis
☐ Nasopharyngeal (Pernasal) swab
☐ Nasopharyngeal wash

Group A *Strep* ☐ Clinical case ☐ Contact with case
☐ Throat swab

Diptheria ☐ Clinical case ☐ Contact with case
☐ Throat swab ☐ Nose swab

Legionella ☐ Bronchoalveolar lavage ☐ Sputum
☐ Bronchial aspirate
☐ Other, specify: _____

GASTROINTESTINAL INFECTIONS

Feces* Sample
☐ Culture and verotoxin
☐ Verotoxin only

Symptoms
Duration: _____ days
☐ Watery diarrhea
☐ Bloody diarrhea
☐ Fever
☐ Other _____

Urine Sample
☐ Culture for *Salmonella* (Follow up for Salmonellosis)

CLINICAL / TRAVEL INFORMATION
☐ Food poisoning/Outbreak ☐ Contact with case
☐ Post infection follow up ☐ Antibiotic usage

TRAVEL: ☐ YES, specify: _____ ☐ NO

Immigration (specify country of origin): _____

***Guideline for Ordering Stool Specimens**
http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/infectious-diarrhea

OTHER TESTS

Consult with Public Health Advanced Bacteriology & Mycology Laboratory before ordering at 604-707-2617

Sample Type: _____

Test Requested: _____

ADDITIONAL CLINICAL / TRAVEL INFORMATION:

_____

_____

For other available tests and additional information, consult the Public Health Laboratory's *eLab Handbook* at www.elabhandbook.info/PHSA/Default.aspx

For information on sample collection, please call Public Health Advanced Bacteriology & Mycology Lab at (604) 707-2617

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Bacteriology and Mycology Requisition
Isolates Submitted for Identification

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(DD/MMM/YYYY)

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(HH:MM)

Section 3 - Test(s) Requested

☐ Bacteria for Identification and/or Further Characterization (Submit pure culture)

☐ Fungus for Identification and/or Further Characterization (Submit pure culture)

Source: _____

Media Isolate Submitted On: _____

Direct Smear of Primary Sample:

Microscopic Morphology of Isolate Submitted:

Colony Morphology:

REFERRING LAB PRELIMINARY BIOCHEMICAL TESTS

BACTERIOLOGY

Growth Conditions:

☐ O_2 ☐ CO_2 ☐ Anaerobic ☐ Microaerophilic

Catalase: ☐ Positive ☐ Negative

Oxidase: ☐ Positive ☐ Negative

Motile: ☐ Yes ☐ No

Growth on MacConkey: ☐ Yes ☐ No

Other: _____

MYCOLOGY

Growth at: ☐ 37°C ☐ 40°C

Germ Tube: ☐ Positive ☐ Negative

Other: _____

Commercial ID System: _____

Suspected Identity: _____

Examination Requested: _____

Supervisor Approval: _____

Date Approved: _____

Contact Email Address: _____

Contact Telephone Number: _____

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