

Section 1 - Patient/Provider Information (Two matching unique patient identifiers on sample container and requisition are required for sample processing)

PERSONAL HEALTH NUMBER (or out-of province Health Number and province)		ORDERING PRACTITIONER Name and MSC#		LABORATORY USE ONLY
PATIENT SURNAME		Address of report delivery		
PATIENT FIRST AND MIDDLE NAME		<input type="checkbox"/> I do not require a copy of the report <input type="checkbox"/> I am a Locum [†] [†] If Locum, include name of Practitioner you are covering for		
DOB (DD/MMM/YYYY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X <input type="checkbox"/> U (Unk)	ADDITIONAL COPIES TO PRACTITIONER / CLINIC: (Name, Address / MSC# / PHSA Client#) (Limit of 3 copies available)		
PATIENT ADDRESS		1.		
CITY		2.		
PROVINCE	POSTAL CODE	3.		
				DATE RECEIVED
				OUTBREAK ID
				SAMPLE REF. NO.
				DATE COLLECTED (DD/MMM/YYYY)
				TIME COLLECTED (HH:MM)

Section 2 - Test(s) Requested

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

SEXUALLY TRANSMITTED INFECTIONS						MYCOLOGY	
Source	Test Requests					<input type="checkbox"/> Sputum <input type="checkbox"/> Bronchial wash <input type="checkbox"/> Body fluid, specify: _____ <input type="checkbox"/> Tissue / Biopsy / Abscess, specify: _____ <input type="checkbox"/> Other, specify: _____ TRAVEL: <input type="checkbox"/> YES, specify: _____ <input type="checkbox"/> NO	
	Chlamydia & Gonorrhea NAT	LGV	Gonorrhea Culture	Trichomonas NAT	Direct Smears		
Cervix	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		CLINICAL INFORMATION: _____ _____ 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 sample collection information, consult the Public Health Laboratory's <i>eLab Handbook</i> at www.elabhandbook.info/PHSA/Default.aspx	
Vagina	<input type="checkbox"/>		No cervix <input type="checkbox"/>	<input type="checkbox"/>	Bacterial vaginosis & yeast <input type="checkbox"/>		
Urethra	<input type="checkbox"/>		<input type="checkbox"/>		Gonorrhea & pus cells <input type="checkbox"/>		
Urine	<input type="checkbox"/>			Female only <input type="checkbox"/>			
Rectal	<input type="checkbox"/>		<input type="checkbox"/>				
Lesion <input type="checkbox"/> Genital <input type="checkbox"/> Rectal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Throat	<input type="checkbox"/>		<input type="checkbox"/>				
Eye	Dry swab <input type="checkbox"/>		<input type="checkbox"/>		Gonorrhea <input type="checkbox"/>		
Nasopharyngeal aspirate or swab (neonates only)	Chlamydia DFA <input type="checkbox"/>						
Tracheobronchial aspirate	Chlamydia DFA <input type="checkbox"/>						
RESPIRATORY INFECTIONS			GASTROINTESTINAL INFECTIONS			ADDITIONAL CLINICAL / TRAVEL INFORMATION: _____ _____ For other available tests and sample collection information, consult the Public Health Laboratory's <i>eLab Handbook</i> at www.elabhandbook.info/PHSA/Default.aspx	
Pertussis <input type="checkbox"/> Nasopharyngeal (Pernasal) swab <input type="checkbox"/> Nasopharyngeal wash Group A Strep <input type="checkbox"/> Clinical case <input type="checkbox"/> Contact with case <input type="checkbox"/> Throat swab Diphtheria <input type="checkbox"/> Clinical case <input type="checkbox"/> Contact with case <input type="checkbox"/> Throat swab <input type="checkbox"/> Nose swab Legionella <input type="checkbox"/> Bronchoalveolar lavage <input type="checkbox"/> Sputum <input type="checkbox"/> Bronchial aspirate <input type="checkbox"/> Other, specify: _____			Feces* Sample <input type="checkbox"/> Culture and verotoxin Duration: _____ days <input type="checkbox"/> Verotoxin only <input type="checkbox"/> Watery diarrhea <input type="checkbox"/> Bloody diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Other _____ Urine Sample <input type="checkbox"/> Culture for <i>Salmonella</i> (Follow up for Salmonellosis)				
CLINICAL / TRAVEL INFORMATION <input type="checkbox"/> Food poisoning/Outbreak <input type="checkbox"/> Contact with case <input type="checkbox"/> Post infection follow up <input type="checkbox"/> Antibiotic usage TRAVEL: <input type="checkbox"/> YES, specify: _____ <input type="checkbox"/> 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							

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<input type="checkbox"/> Bacteria for Identification and/or Further Characterization (Submit pure culture) <input type="checkbox"/> Fungus for Identification and/or Further Characterization (Submit pure culture)	REFERRING LAB PRELIMINARY BIOCHEMICAL TESTS
Source: _____	BACTERIOLOGY
Media Isolate Submitted On: _____	Growth Conditions: <input type="checkbox"/> O ₂ <input type="checkbox"/> CO ₂ <input type="checkbox"/> Anaerobic <input type="checkbox"/> Microaerophilic Catalase: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Oxidase: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Motile: <input type="checkbox"/> Yes <input type="checkbox"/> No Growth on MacConkey: <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____
Direct Smear of Primary Sample:	MYCOLOGY
Microscopic Morphology of Isolate Submitted:	Growth at: <input type="checkbox"/> 37°C <input type="checkbox"/> 40°C Germ Tube: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Other: _____
Colony Morphology:	
Commercial ID System: _____	
Suspected Identity: _____	
Examination Requested: _____	
Supervisor Approval: _____	Contact Email Address: _____
Date Approved: _____	Contact Telephone Number: _____

The personal information collected on this form is collected under the authority of the Personal Information Protection Act. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the Personal Information Protection Act and when applicable the Freedom of Information and Protection of Privacy Act and may be used and disclosed only as provided by those Acts.