

Mandatory information	Patient's Last Name:				Complete MANDATORY information on requisition			
	First Name:				Relevant Clinical/Medication Information:			
	NB Medicare #:			Expiry Date:				
	If no NB Medicare # is present, Other Patient # and Address is required							
	DOB:	D	M	Y	Sex:			
	Ordering Provider:	(First & last name, specialty,)			Copies To:	(First & last name, specialty)		
NOTE: Specimens MUST be labelled with patient's full name, Medicare number, date and time, Phlebotomist Identification								
Collection Date:		Time:		Collected by:				

Specimen / Site	Tests	Specimen / Site	Tests
BLOOD (collect at least 2 sets)		EYES / EARS / NOSE / RESPIRATORY TRACT	
<input type="checkbox"/> Peripheral <input type="checkbox"/> Line <input type="checkbox"/> Site (specify): _____ <input type="checkbox"/> Endocarditis: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Culture (set - Aer/Ana) <input type="checkbox"/> TB Culture <input type="checkbox"/> Other: _____	<input type="checkbox"/> Eye <input type="checkbox"/> Lt <input type="checkbox"/> Rt <input type="checkbox"/> Conjunctiva <input type="checkbox"/> Other	<input type="checkbox"/> Culture <input type="checkbox"/> Viral testing: _____ <input type="checkbox"/> Other testing: _____
BODY FLUIDS (sterile sites)		<input type="checkbox"/> Ear <input type="checkbox"/> Lt <input type="checkbox"/> Rt <input type="checkbox"/> External ear canal <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Joint (site): _____ <input type="checkbox"/> CSF <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Culture <input type="checkbox"/> TB Culture <input type="checkbox"/> Other testing: _____	<input type="checkbox"/> Culture <input type="checkbox"/> Culture for S. aureus	
GENITAL TRACT		<input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Nose/Throat	
<input type="checkbox"/> Cervical / endocervical <input type="checkbox"/> Urethral <input type="checkbox"/> Vaginal <input type="checkbox"/> Pre-menopausal <input type="checkbox"/> Post-menopausal <input type="checkbox"/> Patient on HRT <input type="checkbox"/> Prepubescent <input type="checkbox"/> Post surgery	<input type="checkbox"/> CT/GC DNA <input type="checkbox"/> GC culture <input type="checkbox"/> Viral testing: _____ <input type="checkbox"/> GC culture <input type="checkbox"/> Viral testing: _____ <input type="checkbox"/> CT/GC DNA <input type="checkbox"/> Culture (Nugent score) <input type="checkbox"/> Viral testing: _____ <input type="checkbox"/> Trichomonas <input type="checkbox"/> Culture <input type="checkbox"/> Other: _____	<input type="checkbox"/> Sputum <input type="checkbox"/> CF Patient <input type="checkbox"/> Expecterated <input type="checkbox"/> Suctioned <input type="checkbox"/> Induced <input type="checkbox"/> Culture <input type="checkbox"/> Fungus culture <input type="checkbox"/> TB culture <input type="checkbox"/> Viral testing: _____ <input type="checkbox"/> Other testing: _____	
<input type="checkbox"/> Vaginal / Anal <input type="checkbox"/> Labia / Vulva	<input type="checkbox"/> Group B Strep (GBS) <input type="checkbox"/> Culture (yeast) <input type="checkbox"/> Viral testing: _____	<input type="checkbox"/> Bronchial Wash / Lavage <input type="checkbox"/> Lt <input type="checkbox"/> Rt <input type="checkbox"/> Other: _____ <input type="checkbox"/> Throat <input type="checkbox"/> Oral cavity: _____ Site: _____	
GI TRACT		URINE	
<input type="checkbox"/> Faeces	<input type="checkbox"/> Stool culture <input type="checkbox"/> C. difficile toxin <input type="checkbox"/> Ova and parasites <input type="checkbox"/> Viral testing: _____ <input type="checkbox"/> Helicobacter pylori antigen	<input type="checkbox"/> Midstream <input type="checkbox"/> Indwelling catheter <input type="checkbox"/> Straight (In/Out) catheter <input type="checkbox"/> Cystoscopy <input type="checkbox"/> Culture <input type="checkbox"/> Other testing: _____	
HAIR/ / SKIN / NAILS		<input type="checkbox"/> First void <input type="checkbox"/> First morning (TB)	
<input type="checkbox"/> Hair <input type="checkbox"/> Skin <input type="checkbox"/> Nails Specify site: _____	<input type="checkbox"/> Fungal culture	<input type="checkbox"/> CT/GC DNA <input type="checkbox"/> TB culture	
ANTIBIOTIC RESISTANT SCREENS		WOUNDS / TISSUES	
<input type="checkbox"/> Nares <input type="checkbox"/> Rectal <input type="checkbox"/> Other: _____	<input type="checkbox"/> MRSA culture <input type="checkbox"/> CRE culture <input type="checkbox"/> VRE culture <input type="checkbox"/> Candida auris culture <input type="checkbox"/> ESBL culture	<input type="checkbox"/> Swab <input type="checkbox"/> Surface <input type="checkbox"/> Deep wound <input type="checkbox"/> Abscess / aspirate <input type="checkbox"/> Tissue / biopsy <input type="checkbox"/> Bone Specify site: _____	
OTHER SPECIMENS		TEST REQUESTED	
<input type="checkbox"/> Pinworm paddle <input type="checkbox"/> Worm / Arthropod <input type="checkbox"/> Tick* *Use form HHN-1218 Regional Microbiology Tick Requisition		<input type="checkbox"/> Culture <input type="checkbox"/> TB culture <input type="checkbox"/> Fungus culture <input type="checkbox"/> Viral testing: _____ <input type="checkbox"/> Other testing: _____	

SJ Area Microbiology Requisition

All information MUST be legible

BACK

Appointment Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent <input type="checkbox"/> STAT				<input type="checkbox"/> Non-insured: Horizon Staff <input type="checkbox"/> Non-insured: Private Practice			
Mandatory Information	Patient's Last Name:			Patient Location:			
	First Name:			Account #:			
	NB Medicare #:		Expiry Date:		Other Provincial Healthcare # & Province or Patient #:		
	If no NB Medicare # is present, Other Patient # and Address is required						
	DOB:	D	M	Y	Sex:		
	Ordering Provider:	(First & last name, specialty,)					
	Copies To:	(First & last name, specialty)					
	NOTE: Specimens <u>MUST</u> be labelled with patient's full name, Medicare number, date and time, Phlebotomist Identification						
Collection Date:		Time:		Collection Location:			
Collected by:			Full Signature				

See reverse for culture requests

<p>BLOOD SEROLOGY TESTS</p> <ul style="list-style-type: none"> <input type="checkbox"/> ASOT (anti-streptolysin O titre) <input type="checkbox"/> Cytomegalovirus (CMV) Immune Status (IgG) <input type="checkbox"/> Cytomegalovirus (CMV) Acute Infection (IgM and IgG) <input type="checkbox"/> Herpes Simplex IgG (immune status) Type 1 / Type 2) <input type="checkbox"/> HIV 1,2 antigen/antibody screen (HIV) <input type="checkbox"/> Hepatitis A IgM (acute infection) <input type="checkbox"/> Hepatitis A IgG (immune status) <input type="checkbox"/> Hepatitis B surface antigen (HBsAb) (acute infection) <input type="checkbox"/> Hepatitis B surface antibody (HBsAb) (immune status) <input type="checkbox"/> Hepatitis C antibody (HCV) <input type="checkbox"/> Total Hepatitis B core antibodies (IgM and IgG) <input type="checkbox"/> IGRA <input type="checkbox"/> Lyme serology <input type="checkbox"/> Measles Immune Status (IgG) <input type="checkbox"/> Measles Acute Infection (IgM and IgG) <input type="checkbox"/> Mumps Immune Status (IgG) <input type="checkbox"/> Mumps Acute Infection (IgM and IgG) <input type="checkbox"/> Parvovirus Immune Status (IgG) <input type="checkbox"/> Parvovirus Acute Infection (IgM and IgG) <input type="checkbox"/> Rubella Immune Status (IgG) <input type="checkbox"/> Rubella Acute Infection (IgM and IgG) <input type="checkbox"/> Schistosoma serology <input type="checkbox"/> Strongyloides serology <input type="checkbox"/> Syphilis serology (IgM and IgG) <input type="checkbox"/> Toxoplasma serology (IgM and IgG) <input type="checkbox"/> Varicella Zoster (VZV) Acute Infection (IgM and IgG) <input type="checkbox"/> Varicella Zoster (VZV) Immune Status (IgG) 	<p>BLOOD SEROLOGY PANELS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bloodborne Pathogen - includes HBsAg, HCV, HIV, Syphilis <input type="checkbox"/> Prenatal routine - includes HBsAg, HIV, Rubella IgG, Syphilis <input type="checkbox"/> Needlestick / Body Fluid Exposure <ul style="list-style-type: none"> <input type="checkbox"/> Initial Incident <input type="checkbox"/> Employee <input type="checkbox"/> Patient (source) <input type="checkbox"/> Needle EXP (employee) - includes HBsAg, HBsAb, Total HB core, HCV, HIV, and ALT aminotransferase <input type="checkbox"/> Needle SC (source) - includes HBsAg, HCV, HIV <input type="checkbox"/> Epstein-Barr (EBV) - includes EBV VCA IgM, EBV VCA IgG, and Anti-EBNA <input type="checkbox"/> Red Rash Screen - includes Measles IgG/IgM, Rubella IgG/IgM, Parvovirus IgG/IgM <p>Date of Contact: _____</p> <p>Symptoms: _____</p> <p>Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <input type="checkbox"/> IRCC Panel (Immigration) - includes HBsAg, HBsAb, HIV, Syphilis <p>SPECIMEN REQUIREMENTS</p> <p>Routine serology tests - 5 mL gold SST tubes</p> <p>Bloodborne Pathogen, IRCC, Prenatal, Red Rash, Needle SC, and EBV panels: 1 gold tube</p> <p>Needle EXP Panel - 2 gold tubes</p> <p>TESTS ORDERED INDIVIDUALLY</p> <p>1 tube each for HIV, HCV, HBsAg and Syphilis</p> <p>Other serology tests: 1 tube per 2 tests</p> <p>Viral Loads - 2 x 4 mL lavender EDTA tubes (send to laboratory immediately)</p> <p>Please note: Tubes must be completely filled to avoid rejection</p> <p>OTHER TESTS REQUESTS (please specify):</p>
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