PHSA Laboratories

Public Health Microbiology & Reference Laboratory

BC Centre for Disease Control, 655 West 12th Avenue, Vancouver, BC V5Z 4R4 www.phsa.ca/bccdcpublichealthlab

Bacteriology & Mycology Requisition

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

PHSA LABORATORIES USE ONLY

OUTBREAK ID

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.

SAMPLE REF. NO.

DATE COLLECTED (DD/MMM/YYYY)

TIME COLLECTED (HH:MM)

Section 3 - Test(s) Requested

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

SEXUALLY TRANSMITTED INFECTIONS

Samples for Chlamydia Plus Gonorrhea NAT

☐ Swab ☐ Urine

☐ Urethra ☐ Cervix

☐ Rectal ☐ Throat

Swabs for *N. gonorrhoeae* Culture

☐ Urethra ☐ Cervix ☐ Rectal

☐ Throat ☐ Eye ☐ Vagina (Hysterectomy)

Direct Smears Examined For

☐ Vagina 1 (Slide 1) — Bacterial vaginosis and yeast

☐ Vagina 2 (Slide 2) — *Trichomonas*

☐ Urethra — Gonorrhea and pus cells

☐ Rectal — Gonorrhea

☐ Eye — Gonorrhea

Chlamydia DFA

☐ Eye swab

☐ Nasopharyngeal aspirate OR swab (Neonates only)

☐ Tracheobronchial aspirate (Neonates only)

For other available tests and additional information, consult the Public Health Microbiology & Reference Laboratory's *Guide to Programs and Services* at www.phsa.ca/bccdcpublichealthlab

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: ____________________

MYCOLOGY

☐ Sputum

☐ Bronchial wash

☐ Body fluid, specify:

☐ Tissue / Biopsy / Abscess, specify:

☐ Other, specify:

TRAVEL: ☐ YES, specify: ☐ NO

CLINICAL INFORMATION:

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**
www.bcguidelines.ca/gpac/guideline_diarrhea.html

OTHER TESTS

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

Sample Type:

Test Requested:

ADDITIONAL CLINICAL / TRAVEL INFORMATION:

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

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Isolates Submitted for Identification

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CLINIC OR HOSPITAL Name and address of report delivery **PHSA CLIENT NO.**	

SAMPLE REF. NO.

DATE COLLECTED (DD/MMM/YYYY)

TIME COLLECTED (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: ______________________ Contact Email Address: ______________________

Date Approved: ______________________ Contact Telephone Number: ______________________

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