ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Microbiology Requisition

Alberta Precision Laboratories 1-877-868-6848
Appointment Booking - online at www.albertaprecisionlabs.ca or 1-877-702-4486
Locations and Hours of Operation www.albertaprecisionlabs.ca

Scanning Label or Accession # *(lab only)*

Patient

PHN Expiry: _____	Date of Birth *(dd-Mon-yyyy)*		
Legal Last Name	Legal First Name	Middle Name	
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Phone
Address	City/Town	Prov	Postal Code

Provider(s)

Authorizing Provider Name *(last, first, middle)*		Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*
Address	Phone	Address	Address
CC Provider ID	CC Submitter ID	Phone	Phone
Clinic Name		Clinic Name	Clinic Name

Collection

Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

☒ ***Pregnant***
☐ ***Immunosuppressed***

Antimicrobials

Clinical Information/Suspected Organism

Urine

☒ **Urine Culture, Routine**
☒ Midstream ☐ Indwelling Catheter ☐ In/Out Catheter ☐ Other _____

History required

Symptomatic
☐ Lower UTI/cystitis symptoms or signs
☐ Suspect sepsis/pyelonephritis
☐ UTI in MS or neurogenic bladder

Asymptomatic
☒ Pregnant
☐ Prior to invasive urologic procedure
☐ <1 month post-renal transplant

Respiratory

☐ **Acute Pharyngitis Screen/Culture** *(Group A Streptococcus)*, Throat Swab
☐ Allergy to penicillin ☐ Treatment failure ☐ Indeterminate within 7 days
☐ **Oral Candidiasis Screen**, Swab ☐ Mouth/Gingiva ☐ Tongue ☐ Throat
☐ **Staphylococcus aureus Carrier Culture**, Nares Swab
☐ **Sputum Culture**

Eyes and Ears

☐ **Superficial Eye Culture**, Conjunctival Swab *(specify)* ☐ Left ☐ Right
☐ **Ear Canal Culture, External Ear Swab** *(specify)* ☐ Left ☐ Right
☐ Myringotomy tubes

Wound Swabs

☐ **Superficial Wound Culture** (≤2cm) *(must specify body site)* _____
☐ **Deep Wound Culture** (>2cm) ☐ Wound ☐ Ulcer ☐ Bite ☐ Surgical ☐ Abscess ☐ Diabetic

Stool

☐ **C. difficile Test**
☐ **Bacterial Enteric Panel/Stool Culture** *(Salmonella, Shigella, Campylobacter, STEC)*
Provide additional history if testing for additional pathogens is required.
☐ Raw shellfish exposure ☐ Immunocompromised ☐ Symptoms >1 week
☐ Travel or other history *(specify)* _____
☐ **Stool Parasite Screen** *(Giardia/Cryptosporidium)*
Symptom Onset Date *(required)* _____ Other History_____
☐ **Ova & Parasites, Stool** Requires Parasite History Form - see Test Directory

Parasites

☐ **Malaria** Requires Malaria History Form - see Test Directory
☐ **Pinworm Paddle**
☐ **Parasite/Arthropod/Worm ID** *(specify source)* _____
☐ **Skin Scraping for Scabies** *(specify body site)* _____

Urogenital - Molecular *(Aptima)*

☐ **Vaginitis Screen**,Vaginal Swab *(≥14 years only)* ***Multitest Swab***
(Bacterial Vaginosis, Candida, Trichomonas vaginalis)

☒ **Chlamydia/Gonorrhea Screen** ☒ Urine, First-Catch

History required
☐ Symptomatic/at risk
☒ Prenatal screen *(specify)*
☒ Initial screen
☐ Rescreen
☐ Test of cure

Multitest Swab:
☐ Vagina ☐ Rectum ☐ Throat

Unisex Swab:
☐ Endocervix ☐ Urethra
☐ Left eye ☐ Right eye

☐ **Trichomonas vaginalis Screen**
☐ Vagina ***Multitest Swab***
☐ Endocervix ***Unisex Swab***
☐ Urine, First-Catch

Urogenital - Culture *(ESwab)*

☐ **Group B Streptococcus Screen,** Vaginal/Rectal Swab
☐ Allergy to penicillin

☐ **Genital Culture** ☐ Vaginal ☐ Endocervix ☐ Urethra
History required
☐ Pediatric *(0-13 years)* ☐ Pelvic/GU Surgery
☐ Other *(specify)* _____

☐ **Vaginal Candidiasis Culture** *(History Required)* _____
Refractory/ treatment failure only. For routine diagnosis, order Vaginitis Screen.

☐ **Neisseria gonorrhoeae Culture**
☐ Endocervix ☐ Urethra ☐ Rectum
☐ Throat ☐ Left Eye ☐ Right Eye
History required ☐ Treatment failure ☐ Other *(specify)* _____

Blood, Fluid and Tissues

☐ **Blood Culture** ☐ Peripheral ☐ Central

☐ **Fluid Culture** ☐ Prosthetic Joint/Periprosthetic
☐ Synovial ☐ Bursa ☐ Peritoneal ☐ Aspirate ☐ Drain
☐ Other *(specify body site)* _____

☐ **Tissue Culture** *(specify body site)* _____

Fungal

☐ **Fungal Culture** *(Dermatophytes)* ☐ Skin ☐ Hair ☐ Nail
(must specify body site) _____
☐ **Fungal Culture** *(specify specimen type and body site)* _____

Additional Tests *(specify test and source)*