# 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

**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

**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: ____________________

### 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

### MYCOLOGY

☐ Sputum

☐ Bronchial wash

☐ Body fluid, specify:

____________________

☐ Tissue / Biopsy / Abscess, specify:

____________________

☐ Other, specify:

____________________

**TRAVEL:** ☐ YES, specify: ____________________ ☐ NO

**CLINICAL INFORMATION:**

____________________

### 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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## Bacteriology and Mycology Requisition
## Isolates Submitted for Identification

### 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#)<br>Name and address of report delivery<br>☐ i do not require a copy of the report | ADDITIONAL COPIES TO: (Address / MSC#)<br>1.<br>2.<br>3. |
|---|---|
| CLINIC OR HOSPITAL<br>Name and address of report delivery<br>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: ____________________

Date Approved: ____________________

Contact Email Address: ____________________

Contact Telephone Number: ____________________

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