

**SASKATOON
HEALTH REGION**

**DIVISION OF
LABORATORY MEDICINE**

**BACTERIOLOGY/
MYCOLOGY/TB/
PARASITOLOGY
REQUISITION**

PHN #

Chart #

Patient Name
(Male Female)

Date of Birth Telephone
(DD/MM/YY)

Address

.....

.....

Originating Site: RUH SCH SPH Other:

Requesting Physician:

Additional Copies of Report To: 1. 2.

Collection (Date & Time): Priority: Routine Stat

Pertinent Clinical History _____

Relevant Travel History (give details) _____

Date of Onset of Illness: _____

Antibiotic Therapy: (circle one) NO YES To Be Started

Specify Antibiotics: _____

TEST REQUESTED:

- C. difficile
- Culture & Sensitivity
- Fungal Culture
- G.C.

CHECK BOX OR HIGHLIGHT

- Gram Stain only
- Group A Strep
- Group B Strep
- Ova & Parasites
- Pertussis
- Pinworm
- Pneumocystis carinii (PCP) _____
- TB Culture
- Yeast only
- Other (specify) _____

SPECIMEN TYPE:

- Blood Culture
- Bronchial:
 - aspirate
 - bronchoalveolar lavage
 - washing
- CSF
- Fluid (specify body site/
type of wound) _____
- Gastric washing

CHECK BOX OR HIGHLIGHT

Genital Swabs:

- cervix
- urethra
- vaginal
- vaginal/ anal
- Nasopharyngeal aspirate
- Peritoneal Effluent
- Skin Scrapings (use only with
Fungal Culture)
- Sputum
- Stool
- Throat

~~AI~~ Tissue (specify type) _____

Tracheal Aspirate

Urine:

- ~~AI~~ midstream
- ~~AI~~ straight catheter
- indwelling catheter
- cystoscopy
- other urine (specify): _____
- Wound (specify body site/type of wound)

Other Specimens and Tests (specify): _____