



Section 1 - Patient Information

PERSONAL HEALTH NUMBER (or out-of province Health Number and province)	DOB (DD/MMM/YYYY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK
PATIENT SURNAME	PATIENT FIRST AND MIDDLE NAME	
ADDRESS	CITY	POSTAL CODE

DATE RECEIVED

LABORATORY USE ONLY

OUTBREAK ID

Section 2 - Healthcare Provider Information

ORDERING PHYSICIAN (Provide MSC#) Name and address of report delivery	ADDITIONAL COPIES TO: (Address / MSC#)
<input type="checkbox"/> I do not require a copy of the report	
CLINIC OR HOSPITAL Name and address of report delivery	1. 2. 3.
PHSA CLIENT NO.	

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					
Source	Test Requests				
	Chlamydia & Gonorrhea NAT	LGV	Gonorrhea Culture	Trichomonas NAT	Direct Smears
Cervix	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Vagina	<input type="checkbox"/>		No cervix <input type="checkbox"/>	<input type="checkbox"/>	Bacterial vaginosis & yeast <input type="checkbox"/>
Urethra	<input type="checkbox"/>		<input type="checkbox"/>		Gonorrhea & pus cells <input type="checkbox"/>
Urine	<input type="checkbox"/>			Female only <input type="checkbox"/>	
Rectal	<input type="checkbox"/>		<input type="checkbox"/>		
Lesion <input type="checkbox"/> Genital <input type="checkbox"/> Rectal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Throat	<input type="checkbox"/>		<input type="checkbox"/>		
Eye	Dry swab <input type="checkbox"/>		<input type="checkbox"/>		Gonorrhea <input type="checkbox"/>
Nasopharyngeal aspirate or swab (neonates only)	Chlamydia DFA <input type="checkbox"/>				
Tracheobronchial aspirate	Chlamydia DFA <input type="checkbox"/>				

MYCOLOGY

Sputum

Bronchial wash

Body fluid, specify: _____

Tissue / Biopsy / Abscess, specify: _____

Other, specify: _____

TRAVEL: YES, specify: _____ NO

CLINICAL INFORMATION: _____

RESPIRATORY INFECTIONS

Pertussis

Nasopharyngeal (Pernasal) swab

Nasopharyngeal wash

Group A Strep Clinical case Contact with case

Throat swab

Diphtheria 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

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**
<http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/infectious-diarrhea>

OTHER TESTS

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

Sample Type: _____

Test Requested: _____

ADDITIONAL CLINICAL / TRAVEL INFORMATION: _____

For other available tests and additional information, consult the Public Health Laboratory's eLab Handbook at www.elabhandbook.info/PHSA/Default.aspx



Section 1 - Patient Information

PERSONAL HEALTH NUMBER (or out-of province Health Number and province)	DOB (DD/MMM/YYYY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK
PATIENT SURNAME	PATIENT FIRST AND MIDDLE NAME	
ADDRESS	CITY	POSTAL CODE

DATE RECEIVED
LABORATORY USE ONLY
OUTBREAK ID

Section 2 - Healthcare Provider Information

ORDERING PHYSICIAN (Provide MSC#) Name and address of report delivery	ADDITIONAL COPIES TO: (Address / MSC#) 1. 2. 3.
<input type="checkbox"/> I do not require a copy of the report	
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

<input type="checkbox"/> Bacteria for Identification and/or Further Characterization (Submit pure culture)
<input type="checkbox"/> 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:	
<input type="checkbox"/> O ₂	<input type="checkbox"/> CO ₂ <input type="checkbox"/> Anaerobic <input type="checkbox"/> Microaerophilic
Catalase:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Oxidase:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Motile:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Growth on MacConkey:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	_____
MYCOLOGY	
Growth at:	<input type="checkbox"/> 37°C <input type="checkbox"/> 40°C
Germ Tube:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Other:	_____

Commercial ID System: _____
Suspected Identity: _____
Examination Requested: _____

Supervisor Approval: _____	Contact Email Address: _____
Date Approved: _____	Contact Telephone Number: _____