



Patient	PHN	Expiry: _____	Date of Birth (dd-Mon-yyyy)		
	Legal Last Name		Legal First Name		Middle Name
	Alternate Identifier	Preferred Name	<input type="checkbox"/> Male <input type="checkbox"/> Non-binary	<input type="checkbox"/> Female <input type="checkbox"/> 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
	<input type="checkbox"/> Pregnant <input type="checkbox"/> Immunosuppressed	Antimicrobials	Clinical Information/Suspected Organism		
Urine			Urogenital - Molecular (Aptima)		
<input type="checkbox"/> Urine Culture, Routine <input type="checkbox"/> Midstream <input type="checkbox"/> Indwelling Catheter <input type="checkbox"/> In/Out Catheter <input type="checkbox"/> Other _____ History required Symptomatic _____ Asymptomatic _____ <input type="checkbox"/> Lower UTI/cystitis symptoms or signs <input type="checkbox"/> Pregnant <input type="checkbox"/> Suspect sepsis/pyelonephritis <input type="checkbox"/> Prior to invasive urologic procedure <input type="checkbox"/> UTI in MS or neurogenic bladder <input type="checkbox"/> <1 month post-renal transplant			<input type="checkbox"/> Vaginitis Screen, Vaginal Swab (≥14 years only) Multitest Swab (Bacterial Vaginosis, Candida, Trichomonas vaginalis) <input type="checkbox"/> Chlamydia/Gonorrhoea Screen <input type="checkbox"/> Urine, First-Catch History required <input type="checkbox"/> Symptomatic/at risk Multitest Swab: <input type="checkbox"/> Prenatal screen (specify) <input type="checkbox"/> Vagina <input type="checkbox"/> Rectum <input type="checkbox"/> Throat <input type="checkbox"/> Initial screen Unisex Swab: <input type="checkbox"/> Rescreen <input type="checkbox"/> Endocervix <input type="checkbox"/> Urethra <input type="checkbox"/> Test of cure <input type="checkbox"/> Left eye <input type="checkbox"/> Right eye		
Respiratory <input type="checkbox"/> Acute Pharyngitis Screen/Culture (Group A Streptococcus), Throat Swab <input type="checkbox"/> Allergy to penicillin <input type="checkbox"/> Treatment failure <input type="checkbox"/> Indeterminate within 7 days <input type="checkbox"/> Oral Candidiasis Screen, Swab <input type="checkbox"/> Mouth/Gingiva <input type="checkbox"/> Tongue <input type="checkbox"/> Throat <input type="checkbox"/> Staphylococcus aureus Carrier Culture, Nares Swab <input type="checkbox"/> Sputum Culture			<input type="checkbox"/> Trichomonas vaginalis Screen <input type="checkbox"/> Vagina Multitest Swab <input type="checkbox"/> Endocervix Unisex Swab <input type="checkbox"/> Urine, First-Catch		
Eyes and Ears <input type="checkbox"/> Superficial Eye Culture, Conjunctival Swab (specify) <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Ear Canal Culture, External Ear Swab (specify) <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Myringotomy tubes			Urogenital - Culture (ESwab) <input type="checkbox"/> Group B Streptococcus Screen, Vaginal/Rectal Swab <input type="checkbox"/> Allergy to penicillin <input type="checkbox"/> Genital Culture <input type="checkbox"/> Vaginal <input type="checkbox"/> Endocervix <input type="checkbox"/> Urethra History required <input type="checkbox"/> Pediatric (0-13 years) <input type="checkbox"/> Pelvic/GU Surgery <input type="checkbox"/> Other (specify) _____		
Wound Swabs <input type="checkbox"/> Superficial Wound Culture (≤2cm) (must specify body site) _____ <input type="checkbox"/> Deep Wound Culture (>2cm) <input type="checkbox"/> Wound <input type="checkbox"/> Ulcer <input type="checkbox"/> Bite <input type="checkbox"/> Surgical <input type="checkbox"/> Abscess <input type="checkbox"/> Diabetic			<input type="checkbox"/> Vaginal Candidiasis Culture (History Required) _____ Refractory/ treatment failure only. For routine diagnosis, order Vaginitis Screen.		
Stool <input type="checkbox"/> C. difficile Test <input type="checkbox"/> Bacterial Enteric Panel/Stool Culture (Salmonella, Shigella, Campylobacter, STEC) Provide additional history if testing for additional pathogens is required. <input type="checkbox"/> Raw shellfish exposure <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Symptoms >1 week <input type="checkbox"/> Travel or other history (specify) _____			<input type="checkbox"/> Neisseria gonorrhoeae Culture <input type="checkbox"/> Endocervix <input type="checkbox"/> Urethra <input type="checkbox"/> Rectum <input type="checkbox"/> Throat <input type="checkbox"/> Left Eye <input type="checkbox"/> Right Eye History required <input type="checkbox"/> Treatment failure <input type="checkbox"/> Other (specify) _____		
<input type="checkbox"/> Stool Parasite Screen (Giardia/Cryptosporidium) Symptom Onset Date (required) _____ Other History _____ <input type="checkbox"/> Ova & Parasites, Stool Requires Parasite History Form - see Test Directory			Blood, Fluid and Tissues <input type="checkbox"/> Blood Culture <input type="checkbox"/> Peripheral <input type="checkbox"/> Central <input type="checkbox"/> Fluid Culture <input type="checkbox"/> Prosthetic Joint/Periprosthetic <input type="checkbox"/> Synovial <input type="checkbox"/> Bursa <input type="checkbox"/> Peritoneal <input type="checkbox"/> Aspirate <input type="checkbox"/> Drain <input type="checkbox"/> Other (specify body site) _____		
Parasites <input type="checkbox"/> Malaria Requires Malaria History Form - see Test Directory <input type="checkbox"/> Pinworm Paddle <input type="checkbox"/> Parasite/Arthropod/Worm ID (specify source) _____ <input type="checkbox"/> Skin Scraping for Scabies (specify body site) _____			<input type="checkbox"/> Tissue Culture (specify body site) _____ Fungal <input type="checkbox"/> Fungal Culture (Dermatophytes) <input type="checkbox"/> Skin <input type="checkbox"/> Hair <input type="checkbox"/> Nail (must specify body site) _____ <input type="checkbox"/> Fungal Culture (specify specimen type and body site) _____		
Additional Tests (specify test and source) _____					