

Benefits of providing Alberta Precision Laboratories (APL) with COMPLETE AND LEGIBLE information:

- Promotes patient safety through reduced transcription errors
- Ensures samples are processed for the correct patient and results are sent to the correct provider
- Reduces turnaround time when processing patient samples


Patient full legal name, PHN (or second unique identifier) must match exactly on requisition and specimen

Physician to Act on Results (Ordering physician) is required for laboratory standards. Stamp all requisitions with the physician full last name, first name and address or location code where the report should be sent.

The two letter province code and **Personal Health Number** ensure accurate patient identification and registration. NOTE: Clinibase encounter number is not required for community patients.

For **Copy To** reports indicate the provider full last and first name plus address or location code of where to send report

Date and Time specimen was collected is required

 <input type="checkbox"/> ACH <input type="checkbox"/> FMC <input type="checkbox"/> PLC <input type="checkbox"/> RGH <input type="checkbox"/> SHC <input type="checkbox"/> Other: _____		MICROBIOLOGY REQUISITION <small>SEE OVER FOR ADDITIONAL INFORMATION</small> AFFIX CLINIBASE LABEL and ENCOUNTER NUMBER here – as APPLICABLE		
CLINIC / UNIT		PROVINCE	PERSONAL HEALTH NUMBER (PHN)	REGIONAL HEALTH RECORD NUMBER
ORDERING PHYSICIAN – (Apply CLS Dr. Stamp Here) Last Name / Full First Name: Example, Doctor Office Address: 10 Report Dr. SW 5 Digit Client #: XXXXX 00XXXXA Alpha Suffix Provider #: _____		AB	1 2 3 4 5 – 6 7 8 9	
COPY TO Example Doctor 2 20 Report Dr. NW <small>Last Name Full First Name Office Address/Location</small>		PATIENT LAST NAME	FULL FIRST NAME	MIDDLE NAME
		Example	Patient	A
Alpha Suffix Provider #: _____		PATIENT ADDRESS	CITY, PROVINCE	POSTAL CODE
		22 Happy Way SE	Calgary, AB	T1T 1T1
		CHART NUMBER	GENDER	DATE OF BIRTH
			M	1988 / APR / 22 <small>Y Y Y Y M M M D D</small>
		PATIENT PHONE NUMBER (XXX) XXX – XXXX		
REQUIRED INFORMATION Date & Time Collected: _____ Collected by: _____		<input type="checkbox"/> PREGNANT <input type="checkbox"/> IMMUNOSUPPRESSED ANTIBIOTICS: _____ SUSPECTED ORGANISM/DIAGNOSIS/CLINICAL HISTORY: _____ OTHER TEST REQUESTED (REFER TO GUIDE TO SERVICE): www.calgarylabservices.com <small>IF NOT IN GUIDE TO SERVICES, CONTACT MICROBIOLOGIST ON CALL. CALL LIC 403-770-3600.</small>		

Patient full legal name is required

Patient complete address, gender, date of birth and phone number is required

Clinical Information/History is required

Collected by name is required

Add Clinical data and/or Antibiotics

Always indicate specimen site and source where applicable