

APL Microbiology Requisition Requirements: *Chlamydia trachomatis* / *Neisseria gonorrhoeae* / *Trichomonas vaginalis* Testing

Benefits of providing APL with COMPLETE and LEGIBLE information:

- ✓ Promotes patient safety through reduced transcription errors
- ✓ Ensures samples are tested on the correct patient
- ✓ Ensures results are sent to the correct physician
- ✓ Reduces turn-around time

Patient's NAME and IDENTIFIER must match exactly on requisition and specimen

Patient Information:
Name: Full legal name, complete address, gender, date of birth, and phone number
Patient Identifier: The two letter province code and **Personal Health Number (PHN/ULI)** or Government issued identification (Federal, Military, RCMP, Immigration, Passport #)

Physician Information:
 Full last and first name & full address is required for accurate report delivery OR use APL provided physician stamp

Copy To:
 When additional physicians require a copy of the report add them as a "COPY TO" (Last name, First name, Location)

ORDERING PHYSICIAN <small>(Apply CLS Dr. Office Stamp Here)</small> Last Name / Full First Name: S Digit Client #: Alpha Suffix Provider #:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="3" style="text-align: center;">MICROBIOLOGY REQUISITION</th> </tr> <tr> <td colspan="3" style="text-align: center; font-size: small;">SEE OVER FOR ADDITIONAL INFORMATION</td> </tr> <tr> <td style="width: 33%;"><small>PROVINCE</small></td> <td style="width: 33%;"><small>PERSONAL HEALTH NUMBER (PHN)</small></td> <td style="width: 33%;"><small>REGIONAL HEALTH RECORD NUMBER</small></td> </tr> <tr> <td><small>PATIENT LAST NAME</small></td> <td><small>FULL FIRST NAME</small></td> <td><small>MIDDLE NAME</small></td> </tr> <tr> <td colspan="3"><small>PATIENT ADDRESS</small></td> </tr> <tr> <td colspan="2"></td> <td style="text-align: right;"><small>CITY, PROVINCE</small></td> </tr> <tr> <td colspan="3" style="text-align: right;"><small>POSTAL CODE</small></td> </tr> <tr> <td><small>CHART NUMBER</small></td> <td><small>GENDER</small></td> <td><small>DATE OF BIRTH</small></td> </tr> <tr> <td colspan="2"></td> <td style="text-align: right;"><small>PATIENT PHONE NUMBER</small></td> </tr> </table>	MICROBIOLOGY REQUISITION			SEE OVER FOR ADDITIONAL INFORMATION			<small>PROVINCE</small>	<small>PERSONAL HEALTH NUMBER (PHN)</small>	<small>REGIONAL HEALTH RECORD NUMBER</small>	<small>PATIENT LAST NAME</small>	<small>FULL FIRST NAME</small>	<small>MIDDLE NAME</small>	<small>PATIENT ADDRESS</small>					<small>CITY, PROVINCE</small>	<small>POSTAL CODE</small>			<small>CHART NUMBER</small>	<small>GENDER</small>	<small>DATE OF BIRTH</small>			<small>PATIENT PHONE NUMBER</small>
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Indicate **Date and time** of specimen collection

UROGENITAL: For surgical/traumatic urogenital wounds/abscess superficial wound section	
<input type="checkbox"/> Chlamydia/Gonorrhea History required <input type="checkbox"/> Symptomatic/At Risk <input type="checkbox"/> Pregnant	<input type="checkbox"/> Vaginal (Vaginal specimen preferred) <i>PINK Aptima VAG swab (orange label)</i> <input type="checkbox"/> Urine - initial 30 mL only <input type="checkbox"/> Urethral <input type="checkbox"/> Rectal <input type="checkbox"/> Endocervical <i>BLUE Aptima UNISEX swab (white label)</i>
<input type="checkbox"/> Trichomonas vaginalis	<input type="checkbox"/> Vaginal (Vaginal specimen preferred) <i>PINK Aptima VAG swab (orange label)</i> <input type="checkbox"/> Urine - initial 30 mL only <input type="checkbox"/> Urethral <i>BLUE Aptima UNISEX swab (white label)</i>
<input type="checkbox"/> Bacterial vaginosis/Yeast	<input type="checkbox"/> Vaginal <i>Amies swab-red</i>
<input type="checkbox"/> Group B Strep (GBS) (Prenatal Screen)	<input type="checkbox"/> Vaginal/rectal <i>Amies swab-red</i> <input type="checkbox"/> Allergy to penicillin
<input type="checkbox"/> Gonorrhea Culture treatment failure ONLY (must have prev. GC + result)	<input type="checkbox"/> Endocervical <input type="checkbox"/> Urethral <input type="checkbox"/> Rectal <i>Amies charcoal swab</i>
<input type="checkbox"/> Mycoplasma/Ureaplasma	<input type="checkbox"/> Endocervical <input type="checkbox"/> Vaginal <input type="checkbox"/> Urethral <i>Mycoplasma Transport Media</i>
<input type="checkbox"/> Toxic shock syndrome	<input type="checkbox"/> Vaginal <i>Amies swab-red</i>

Indicate **specimen site and source**