

Benefits of providing CLS with COMPLETE and LEGIBLE information:

- ✔ Promotes patient safety through reduced transcription errors
- ✔ Ensures samples are processed for the correct patient and tests are sent to the correct provider
- ✔ Reduces turn around time when processing patient samples

Ordering physician is required for laboratory standards.

- ✔ Please stamp all requisitions with the physician's stamp provided by CLS

The two letter province code and Personal Health Number ensure accurate patient identification and registration

Patient's full legal name, complete address, gender, date of birth, and phone number ensure accurate patient ID

If additional "COPY TO" reports are needed – last name, first name and location are required

ORDERING PHYSICIAN		LABORATORY REQUISITION	
Dr. Fred Smith All Smiles Med Clinic 222-456 Happy Dr. SW		PROVINCE: AB PERSONAL HEALTH NUMBER (PHN): 1 2 3 4 5 - 6 7 8 9	
COPY TO: Cole Jonathan Market Mall		PATIENT LAST NAME: Example FULL FIRST NAME: Patient	
Infection/Diagnosis/Suspected Organism: _____ Antibiotics: _____		PATIENT ADDRESS: 22 Happy Way SE CITY, PROVINCE: Calgary, AB	
IMMUNOSUPPRESSED: <input type="checkbox"/> YES <input type="checkbox"/> NO NEUTROPENIC: <input type="checkbox"/> YES <input type="checkbox"/> NO		CHART NUMBER: _____ GENDER: F DATE OF BIRTH: 1 9 8 8 / May / 2 2 40 5	
MOUTH/NOSE/THROAT/RESPIRATORY/EYE		URINE/STOOL	
<input type="checkbox"/> Mouth/Gingiva/Tongue	<input type="checkbox"/> Candida/Vincent's <input type="checkbox"/> Herpes (HSV) DFA slide req'd	<input type="checkbox"/> Urine - Midstream (MSU) <input type="checkbox"/> Urine - Catheter <input type="checkbox"/> Urine - Other specify source:	<input type="checkbox"/> Bacterial Culture (C & S) <input type="checkbox"/> Candida/Yeast
<input type="checkbox"/> Nose/Nasal	<input type="checkbox"/> S. aureus screen OR <input type="checkbox"/> MRSA screen	<input type="checkbox"/> Urine - collect initial stream Testing only performed when history provided at right	<input type="checkbox"/> Chlamydia/GC <input type="checkbox"/> less than 35 years old <input type="checkbox"/> Symptomatic/At Risk <input type="checkbox"/> Pregnant <input type="checkbox"/> Planning Pregnancy
Nasopharyngeal (specify): <input type="checkbox"/> aspirate <input type="checkbox"/> wash <input type="checkbox"/> swab	<input type="checkbox"/> RSV	<input type="checkbox"/> Stool	<input type="checkbox"/> Bacterial Culture (C & S) <input type="checkbox"/> Clostridium difficile toxin
<input type="checkbox"/> Throat	<input type="checkbox"/> Group A Strep (GAS) <input type="checkbox"/> Allergy to Penicillin/Rx Failure <input type="checkbox"/> Other - specify:	<input type="checkbox"/> Stool - Giardia/Cryptosp Screen only	<input type="checkbox"/> Giardia/Cryptosporidium Screen Patient history not required
<input type="checkbox"/> Throat Cystic fibrosis (CF) - ACH	<input type="checkbox"/> CF Protocol	<input type="checkbox"/> Stool - Full Ova & Parasitology	<input type="checkbox"/> Full O & P Includes Giardia/Cryptosporidium Screen
<input type="checkbox"/> Sputum <input type="checkbox"/> E-tube aspirate <input type="checkbox"/> T-tube aspirate	<input type="checkbox"/> Bacterial Culture (C & S) <input type="checkbox"/> Candida/Yeast	Te hi N Di	
<input type="checkbox"/> Sputum Cystic Fibrosis	<input type="checkbox"/> Fungal Culture <input type="checkbox"/> Adult CF Protocol <input type="checkbox"/> Pediatric CF Protocol		
<input type="checkbox"/> Bronchoalveolar lavage (BAL) <input type="checkbox"/> Bronchial Wash (BW)	<input type="checkbox"/> Bacterial Culture (C & S)		

Always indicate specimen site and source where applicable

Include patient history when requested on the requisition to ensure appropriate testing is performed

UROGENITAL: For surgical/traumatic urogenital wounds/abscesses complete superficial wound section	
<input type="checkbox"/> Cervical or <input type="checkbox"/> Vaginal vault > 35 years old testing only performed when history provided at right	<input type="checkbox"/> Chlamydia/GC - <input type="checkbox"/> Symptomatic/At Risk <input type="checkbox"/> Pregnant <input type="checkbox"/> Planning Pregnancy
<input type="checkbox"/> Cervical or <input type="checkbox"/> Vaginal vault	<input type="checkbox"/> GC Culture: Treatment failure only
<input type="checkbox"/> Vaginal/Adult (13 v	<input type="checkbox"/> Mycoplasma/Ureaplasma
<input type="checkbox"/> Vaginal vault	<input type="checkbox"/> Trichomonas vaginalis
	<input type="checkbox"/> Mycoplasma/Ureaplasma
	<input type="checkbox"/> Toxic shock syndrome

Always indicate specimen site and source where applicable

Include patient history when requested on the requisition to ensure appropriate testing is performed

REQUIRED INFORMATION	
Date & Time Collected:	Collected by:

Date and time the specimen was collected is required