ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

STI Test Requisition
(Bacteriology)

Scanning Label or Accession # *(lab only)*

ProvLab - Calgary Phone 403.944.1200 Edmonton Phone 780.407.7121

Patient

PHN Expiry: _____	Date of Birth *(dd-Mon-yyyy)*		
Legal Last Name	Legal First Name	Middle Name	
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ 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	Legacy ID	Phone	Phone
Clinic Name		Clinic Name	Clinic Name

Collection

Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

Request test below by **marking X** in appropriate box and column

Site	N. gonorrhoeae (culture) **M GC**	N. gonorrhoeae/C. trachomatis (NAAT) **M CHLAMGC**
Urine	*Not applicable*	☐ *Lab place label here*
Cervix(Cx) ☐ Test of Cure	☐ *Lab place label here*	☐ *Lab place label here*
Throat (T) ☐ Test of Cure	☐ *Lab place label here*	☐ *Lab place label here*
Rectal (R) ☐ Test of Cure	☐ *Lab place label here*	☐ *Lab place label here*
Urethra (U) ☐ Test of Cure	☐ *Lab place label here*	☐ *Lab place label here*
Eye (E) ☐ **Left** ☐ **Right** ☐ Test of Cure	☐ *Lab place label here*	☐ *Lab place label here*
Vault ☐ Test of Cure	☐ *Lab place label here*	☐ *Lab place label here*
Vagina (V) ☐ Test of Cure	☐ Bacterial Vaginosis (smear only) **M BVYST**	☐ N. gonorrhoeae/C. trachomatis (NAAT) **M CHLAMGC**

Other Test	Specimen type/site	History

ALBERTA PRECISION LABORATORIES
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STI Test Requisition
(Virology)

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Scanning Label or Accession # *(lab only)*

Patient

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Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose		Phone
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Address		Phone	Address	Address
CC Provider ID	CC Submitter ID	Legacy ID	Phone	Phone
Clinic Name			Clinic Name	Clinic Name

Collection

Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

Request test below by **marking X** in appropriate box and column

Site	Herpes simplex PCR *(swab in UTM)* **HS VZ PCR**	
Lesion Specify Site: _____	☐	*Lab place label here*
Cervix(Cx)	☐	*Lab place label here*
Urethra (U	☐	*Lab place label here*

Site	Syphilis PCR *(swab in UTM)* **SYPH PCR**	
Lesion Specify Site: _____	☐	*Lab place label here*

Site	Herpes simplex, enterovirus, parechovirus and adenovirus PCR *(swab in UTM)* **EYE PANEL**	
Eye (E) *(Left)*	☐	*Lab place label here*
Eye (E) *(Right)*	☐	*Lab place label here*

Other Test

Type of Test	Specimen type/site	History

Serology - Blood

☐ Hep A **IgG HAV IGG PROV** ☐ HBc Total Ab **HBC TOT PROV**
☐ HBsAg **HBV SAG PROV**
☐ Anti HBs **HBV SAB PROV**
☐ Anti HCV **HCV AB**
☐ Other Serology:_____

Place Lab Accession Label here

☐ **Syphilis SYPH PROV**
Previous Syphilis test ☐ Negative ☐ Positive ☐ Never Done ☐ Unknown
Received treatment? ☐ No ☐ Yes

☐ H**IV HIV AG/AB PROV**
Previous HIV Test ☐ Negative ☐ Positive ☐ Never Done ☐ Unknown

Lab Accession # _____ OR Date of previous test _____