



Section 1 - Patient Information

|   |                                      |  |
|---|--------------------------------------|--|
| <b>PERSONAL HEALTH NUMBER</b> (or out-of province Health Number and province) | <b>DOB</b> (DD/MMM/YYYY)             | <b>GENDER</b> <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK |
| <b>PATIENT SURNAME</b>  | <b>PATIENT FIRST AND MIDDLE NAME</b> |  |
| <b>ADDRESS</b>  | <b>CITY</b>                          | <b>POSTAL CODE</b>   |

DATE RECEIVED

**LABORATORY USE ONLY**

OUTBREAK ID

Section 2 - Healthcare Provider Information

|   |   |
|---|---|
| <b>ORDERING PHYSICIAN</b> (Provide MSC#)<br>Name and address of report delivery | <b>ADDITIONAL COPIES TO:</b> (Address / MSC#)<br><br>1.<br><br>2.<br><br>3. |
| <input type="checkbox"/> I do not require a copy of the report                  |   |
| <b>CLINIC OR HOSPITAL</b><br>Name and address of report delivery                |   |
| <b>PHSA CLIENT NO.</b>  |   |

**SAMPLE REF. NO.**

**DATE COLLECTED**  
(DD/MMM/YYYY)

**TIME COLLECTED**  
(HH:MM)

Section 3 - Test(s) Requested

USE REVERSE SIDE TO SUBMIT ISOLATES FOR IDENTIFICATION AND/OR TYPING

| SEXUALLY TRANSMITTED INFECTIONS   |  |                          |                                    |                                      |  |
|---|--|--------------------------|------------------------------------|--------------------------------------|--|
| Source  | Test Requests                          |                          |                                    |                                      |  |
|   | Chlamydia & Gonorrhea NAT              | LGV                      | Gonorrhea Culture                  | Trichomonas NAT                      | Direct Smears  |
| Cervix  | <input type="checkbox"/>               |                          | <input type="checkbox"/>           | <input type="checkbox"/>             |  |
| Vagina  | <input type="checkbox"/>               |                          | No cervix <input type="checkbox"/> | <input type="checkbox"/>             | Bacterial vaginosis & yeast <input type="checkbox"/> |
| Urethra   | <input type="checkbox"/>               |                          | <input type="checkbox"/>           |                                      | Gonorrhea & pus cells <input type="checkbox"/>       |
| Urine   | <input type="checkbox"/>               |                          |                                    | Female only <input type="checkbox"/> |  |
| Rectal  | <input type="checkbox"/>               |                          | <input type="checkbox"/>           |                                      |  |
| Lesion <input type="checkbox"/> Genital <input type="checkbox"/> Rectal | <input type="checkbox"/>               | <input type="checkbox"/> | <input type="checkbox"/>           |                                      |  |
| Throat  | <input type="checkbox"/>               |                          | <input type="checkbox"/>           |                                      |  |
| Eye   | Dry swab <input type="checkbox"/>      |                          | <input type="checkbox"/>           |                                      | Gonorrhea <input type="checkbox"/>                   |
| Nasopharyngeal aspirate or swab (neonates only)                         | Chlamydia DFA <input type="checkbox"/> |                          |                                    |                                      |  |
| Tracheobronchial aspirate   | Chlamydia DFA <input type="checkbox"/> |                          |                                    |                                      |  |

**MYCOLOGY**

Sputum

Bronchial wash

Body fluid, specify: \_\_\_\_\_

Tissue / Biopsy / Abscess, specify: \_\_\_\_\_

Other, specify: \_\_\_\_\_

**TRAVEL:**  YES, specify: \_\_\_\_\_  NO

**CLINICAL INFORMATION:** \_\_\_\_\_

**RESPIRATORY INFECTIONS**

**Pertussis**

Nasopharyngeal (Pernasal) swab

Nasopharyngeal wash

**Group A Strep**  Clinical case  Contact with case

Throat swab

**Diphtheria**  Clinical case  Contact with case

Throat swab  Nose swab

**Legionella**  Bronchoalveolar lavage  Sputum

Bronchial aspirate

Other, specify: \_\_\_\_\_

**GASTROINTESTINAL INFECTIONS**

**Feces\* Sample**

Culture and verotoxin

Verotoxin only

**Urine Sample**

Culture for *Salmonella* (Follow up for Salmonellosis)

**CLINICAL / TRAVEL INFORMATION**

Food poisoning/Outbreak  Contact with case

Post infection follow up  Antibiotic usage

**TRAVEL:**  YES, specify: \_\_\_\_\_  NO

Immigration (specify country of origin): \_\_\_\_\_

**\*Guideline for Ordering Stool Specimens**  
<http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/infectious-diarrhea>

**OTHER TESTS**

Consult with Public Health Advanced Bacteriology & Mycology Laboratory before ordering at 604-707-2617

Sample Type: \_\_\_\_\_

Test Requested: \_\_\_\_\_

**ADDITIONAL CLINICAL / TRAVEL INFORMATION:** \_\_\_\_\_

\_\_\_\_\_

For other available tests and additional information, consult the Public Health Laboratory's eLab Handbook at [www.elabhandbook.info/PHSA/Default.aspx](http://www.elabhandbook.info/PHSA/Default.aspx)



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Bacteria for Identification and/or Further Characterization (Submit pure culture)

Fungus for Identification and/or Further Characterization (Submit pure culture)

Source: \_\_\_\_\_

Media Isolate Submitted On: \_\_\_\_\_

Direct Smear of Primary Sample:

Microscopic Morphology of Isolate Submitted:

Colony Morphology:

**REFERRING LAB PRELIMINARY BIOCHEMICAL TESTS**

**BACTERIOLOGY**

Growth Conditions:  
 O<sub>2</sub>     CO<sub>2</sub>     Anaerobic     Microaerophilic

Catalase:     Positive     Negative

Oxidase:     Positive     Negative

Motile:     Yes     No

Growth on MacConkey:     Yes     No

Other: \_\_\_\_\_

**MYCOLOGY**

Growth at:     37°C     40°C

Germ Tube:     Positive     Negative

Other: \_\_\_\_\_

Commercial ID System: \_\_\_\_\_

Suspected Identity: \_\_\_\_\_

Examination Requested: \_\_\_\_\_

Supervisor Approval: \_\_\_\_\_      Contact Email Address: \_\_\_\_\_

Date Approved: \_\_\_\_\_      Contact Telephone Number: \_\_\_\_\_