



BC Centre for Disease Control
An agency of the Provincial Health Services Authority

Public Health Laboratory

655 West 12th Avenue, Vancouver, BC V5Z 4R4
www.bccdc.ca/publichealthlab

Bacteriology & Mycology Requisition



LABS

Section 1 - Patient Information

PERSONAL HEALTH NUMBER (or out-of province Health Number and province)	DOB (DD/MMM/YYYY)	GENDER ☐ M ☐ F ☐ UNK
PATIENT SURNAME	PATIENT FIRST AND MIDDLE NAME	
ADDRESS	CITY	POSTAL CODE

DATE RECEIVED
LABORATORY USE ONLY
OUTBREAK ID

Section 2 - Healthcare Provider Information

ORDERING PHYSICIAN (Provide MSC#) Name and address of report delivery	ADDITIONAL COPIES TO: (Address / MSC#) 1. 2. 3.
☐ I do not require a copy of the report	
CLINIC OR HOSPITAL Name and address of report delivery	
PHSA CLIENT NO.	

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						MYCOLOGY	
Source	Test Requests						
	Chlamydia & Gonorrhea NAT	LGV	Gonorrhea Culture	Trichomonas NAT	Direct Smears		
Cervix	☐		☐	☐			☐ Sputum
Vagina	☐		No cervix ☐	☐	Bacterial vaginosis & yeast ☐		☐ Bronchial wash
Urethra	☐		☐		Gonorrhea & pus cells ☐		☐ Body fluid, specify: _____
Urine	☐			Female only ☐			☐ Tissue / Biopsy / Abscess, specify: _____
Rectal	☐		☐				☐ Other, specify: _____
Lesion ☐ Genital ☐ Rectal	☐	☐	☐				TRAVEL: ☐ YES, specify: _____ ☐ NO
Throat	☐		☐				CLINICAL INFORMATION: _____
Eye	Dry swab ☐		☐		Gonorrhea ☐		
Nasopharyngeal aspirate or swab (neonates only)	Chlamydia DFA ☐						
Tracheobronchial aspirate	Chlamydia DFA ☐						

RESPIRATORY INFECTIONS		GASTROINTESTINAL INFECTIONS		OTHER TESTS
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: _____	Feces* Sample ☐ Culture and verotoxin ☐ Verotoxin only Urine Sample ☐ Culture for <i>Salmonella</i> (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	Symptoms Duration: _____ days ☐ Watery diarrhea ☐ Bloody diarrhea ☐ Fever ☐ Other _____ 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		

For information on sample collection, please call Public Health Advanced Bacteriology & Mycology Lab at (604) 707-2617

Form DCBM_100_1001F Version 5.0 08/2017
PHSA ePro# 00055689



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Bacteriology and Mycology Requisition Isolates Submitted for Identification



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☐ Bacteria for Identification and/or Further Characterization (Submit pure culture) ☐ Fungus for Identification and/or Further Characterization (Submit pure culture)	REFERRING LAB PRELIMINARY BIOCHEMICAL TESTS BACTERIOLOGY Growth Conditions: ☐ O ₂ ☐ CO ₂ ☐ Anaerobic ☐ Microaerophilic Catalase: ☐ Positive ☐ Negative Oxidase: ☐ Positive ☐ Negative Motile: ☐ Yes ☐ No Growth on MacConkey: ☐ Yes ☐ No Other: _____
Source: _____ Media Isolate Submitted On: _____	
Direct Smear of Primary Sample: _____	
Microscopic Morphology of Isolate Submitted: _____	MYCOLOGY Growth at: ☐ 37°C ☐ 40°C Germ Tube: ☐ Positive ☐ Negative Other: _____
Colony Morphology: _____	
Commercial ID System: _____ Suspected Identity: _____ Examination Requested: _____	
Supervisor Approval: _____ Date Approved: _____	
Contact Email Address: _____ Contact Telephone Number: _____	