

### Instructions

- Use ONE requisition per specimen submission  
 Requisition must have completed physician and patient information  
 Clearly label CONTAINER with:
1. Patient full name (last name and first name)
  2. Date of birth
  3. Personal Health Number (PHN)
  4. Date of collection
  5. Specimen source

### NOTE:

 The Specimen will be rejected if:

- The sample container is UNLABELLED
- There is incomplete information on the requisition
- Sample received leaking or in a damaged transport container

Ordering Physician:		Code	Patient PHN	D O B	yyyy	mon	dd	Copy to Dr:	Code
Address			Patient Name (Last/ First)			<input type="checkbox"/> M <input type="checkbox"/> F		Address	
City	Prov	Postal Code	Address				City Prov Postal Code		
Phone No.	Fax No.		City		Prov	Postal Code		Fax No.	
Date/ Time of Collection	Diagnosis		Recent Travel (indicate country)		Occupation		El#	Sender Lab Number	
yyy / mon / dd		hr							
<b>SPECIMEN TYPE AND SOURCE</b>									
<input type="checkbox"/> Auger Suction <input type="checkbox"/> Blood <input type="checkbox"/> Bronchoalveolar Lavage _____ <input type="checkbox"/> CSF <input type="checkbox"/> Cervical Swab <input type="checkbox"/> Environmental Water (specify) _____			<input type="checkbox"/> Fluid (specify) _____ <input type="checkbox"/> Nasopharyngeal Aspirate <input type="checkbox"/> Nasopharyngeal Swab <input type="checkbox"/> Rectal Swab <input type="checkbox"/> Sputum _____ <input type="checkbox"/> Stool			<input type="checkbox"/> Tissue (specify) _____ <input type="checkbox"/> Throat Swab <input type="checkbox"/> Urethral Swab <input type="checkbox"/> Vaginal Swab <input type="checkbox"/> Organism (specify) _____ <input type="checkbox"/> Other (specify) _____			
<b>TEST REQUEST</b>									
<input type="checkbox"/> Bacterial Vaginosis <input type="checkbox"/> Bacterial Culture <input type="checkbox"/> Susceptibility Testing <input type="checkbox"/> Food Poisoning Organisms <input type="checkbox"/> Full Work-up <input type="checkbox"/> Specify _____ <input type="checkbox"/> Fungi <input type="checkbox"/> Culture <input type="checkbox"/> Identification <input type="checkbox"/> Genital Mycoplasma Culture <input type="checkbox"/> Gonococcus <input type="checkbox"/> Culture <input type="checkbox"/> PCR			<input type="checkbox"/> Legionella Culture <input type="checkbox"/> Mycobacteria (AFB) <input type="checkbox"/> Parasite Investigation <input type="checkbox"/> Pertussis PCR <input type="checkbox"/> Serology (Bacterial, Fungal, Parasite) <input type="checkbox"/> Reference Identification (specify) _____ <input type="checkbox"/> Other (specify) _____						
<b>Comments / Clinical Details:</b>								<b>LAB USE ONLY</b>	
								Accession Number	
								Test Code	

 Requisitions are available for printing from [www.provlab.ab.ca](http://www.provlab.ab.ca)