FOR OUTPATIENTS: Please attach a copy of the registration FACESHEET and INSURANCE Card(s) to this form

Patient Care Location	Collect Date:	Collect Time:	**MEDICAL RECORD#**
Print Ordering Physician/Practitioner **NAME REQUIRED**			**NAME**:
Ordering Physician/Practitioner **SIGNATURE REQUIRED**			**DOB:** **GENDER:**
Attending Physician NAME (if different than ordering)			
Routine ☐ STAT ☐	Phone:	Pager:	

NOTE: All tests should be MEDICALLY NECESSARY, as supported by the medical record for diagnosis or treatment, *NOT FOR SCREENING*.
OUTPATIENT requests require Clinical Indications for tests: PLEASE INCLUDE ICD10 CODE(S) FOR SIGN, SYMPTOM, OR DEFINITIVE DIAGNOSIS
@Indicates Limited Payment Coverage Test

TESTS: MARK WITH X Must also complete specimen source section (MAY MARK MULTIPLE TESTS ON SAME SPECIMEN)

ICD10 CODE

BACTERIOLOGY

☐ ROUTINE CULTURE and SUSCEPTIBILITY _____
(includes direct smear if enough material submitted)
☐ ANAEROBE CULTURE _____
☐ SMEAR ONLY _____
☐ BODY FLUID CULTURE and SUSCEPTIBILITY _____
(INCLUDES DIRECT SMEAR)
☐ BETA STREPTOCOCCUS SCREEN CULTURE (THROAT)
☐ GROUP B STREP BY PCR (VAGINAL/RECTAL)
☐ BLOOD CULTURE: PERIPHERAL VEIN DRAW _____
☐ BLOOD CULTURE: LINE DRAW: _____
SPECIFY LINE: _____
☐ GENITAL CULTURE _____
☐ PRE-SURG STAPH SCREEN MRSA / _____
S. AUREUS (NARES)
☐ MRSA SCREEN, NARES AND SECOND SITE _____
SPECIFY: _____
☐ NEISSERIA SCREEN CULTURE _____
(RESPIRATORY, RECTAL, GENITAL)
☐ RESPIRATORY CULTURE, BACTERIAL _____
(MAY ALSO INCLUDE SMEAR & SUSCEPTIBILITY)
☐ MOLECULAR GROUP A BETA STREP, _____
☐ MOLECULAR ENTERIC PANEL _____
(SALMONELLA, CAMPYLOBACTER, SHIGELLA / ENTEROINVASIVE ECOLI, SHIGATOXIN 1 AND SHIGATOXIN 2 GENES)
☐ STOOL SPECIAL PATHOGEN: SPECIFY _____
(EG,AEROMONAS/PLESIOMONAS/YERSINIA/VIBRO)
☐ C. DIFFICILE TOXIN ASSAY BY PCR _____
☐ URINE CULTURE and SUSCEPTIBILITY _____
☐ NEISSERIA (GC) AND CHLAMYDIA _____
AMPLIFIED PROBE
☐ NEISSERIA (GC) AMPLIFIED PROBE _____
☐ CHLAMYDIA AMPLIFIED PROBE _____
☐ VAGINITIS DIRECT PROBE: TRICHOMONAS _____
GARDNERELLA & CANDIDA
☐ OTHER (SPECIFY) _____

MOLECULAR MICROBIOLOGY

☐ INFLUENZA A & B AND RSV PCR _____
☐ MOLECULAR RESPIRATORY PANEL _____
IMMUNE COMPROMISED PATIENTS
☐ ENTEROVIRUS BY PCR _____
☐ VARICELLA ZOSTER BY PCR _____
☐ HSV 1 AND 2 BY PCR _____
☐ CMV VIRAL LOAD _____
☐ EBV VIRAL LOAD _____
☐ HIV VIRAL LOAD _____
☐ BK VIRUS _____

THE OHIO STATE UNIVERSITY MEDICAL CENTER
MICROBIOLOGY LABORATORY REQUISITION

THIS SECTION IS MANDATORY
SPECIMEN SOURCE (one specimen per requisition)

☐ URINE, CLEAN CATCH
☐ URINE, CATHETERIZED
☐ URINE, FIRST CATCH (GC & Chlamydia, AMPLIFIED PROBE)
☐ BLOOD
☐ CERVIX
☐ URETHRA / PENIS
☐ STOOL
☐ SPUTUM EXPECTORATED
☐ SPUTUM ASPIRATED
☐ THROAT
☐ NASOPHARYNX
☐ CEREBRAL SPINAL FLUID

☐ BAL (BRONCHOALVEOLAR LAVAGE)
☐ OTHER FLUID: SPECIFY _____
☐ TISSUE: SPECIFY _____

PATIENT HISTORY:
ANTIBIOTICS
☐ NO
☐ YES

PURPOSE OF CULTURE:
☐ DIAGNOSIS
☐ MANAGEMENT
☐ FOLLOW UP

PARASITOLOGY

☐ PARASITE, ANTIGEN SCREEN STOOL: _____
(FOR GIARDIA, CRYPTOSPORIDIA, E. HISTOLYTICA)
☐ COMPREHENSIVE OVA & PARASITE EXAM _____
(CHECK BELOW) NOT DONE IN HOUSE-SENT OUT
☐ IMMUNOCOMPROMISED
☐ TRAVEL HISTORY: _____
☐ SUSPECTED PARASITE: _____
☐ PINWORM EXAM (PERIRECTAL PREP) _____
☐ OTHER PARASITE: SPECIFY _____

MYCOBACTERIOLOGY / MYCOLOGY CULTURE

☐ AFB / MYOCARBACTERIA CULTURE (INCLUDES _____
DIRECT SMEAR* IF ENOUGH MATERIAL SUBMITTED)
*1ST TIME SMEAR POSITIVE PATIENT REFLEXES TO M.TB PCR
☐ M. TUBERCULOSIS PCR _____
☐ FUNGUS CULTURE ☐ FUNGUS SMEAR _____
☐ YEAST SCREEN
☐ LEGIONELLA CULTURE

FOR LABORATORY USE ONLY
GROSS DESCRIPTION (CIRCLE)

SWAB	FLUID	TISSUE	STOOL
ONE	CLEAR	TINY	FORMED
TWO	CLOUDY	SMALL	UNFORMED
THREE	BLOODY	MEDIUM	WATERY
	UCTERIC	LARGE	BLOODY
	VOL		MUCOID

March 2016