

A-1a Pathology Doctor's Order

● File most recent sheet of this number ON BOTTOM ●

Clinical Microbiology Laboratory
 Department of Pathology — 6004 BT
 200 Hawkins Drive, Iowa City, IA 52242
 Phone (319) 356-2591

LOCATION (or VISIT #)

DATE:

HOSP. #:

NAME:

BIRTH DATE:

ADDRESS:

CHARGE TO:

IF NOT IMPRINTED, PLEASE PRINT DATE, HOSP. #, NAME AND LOCATION

I request the Laboratory to perform all testing on this specimen including but not limited to cultures, direct smear exams and antimicrobial susceptibility testing that are deemed medically necessary.

Physician's signature Date Time

Physician's name/number

Collected by (initials) Time Collected

MD Phleb
 Nurse LIP

Clinical Data / ICD-9-CM Code:

Specimen Description: Circle or check appropriate specimen and fill in requested information.

- BLOOD** Venipuncture Catheter
 Other
- CSF** Lumbar puncture Ventricular tap
- BODY FLUID** Peritoneal fluid Pleural fluid Synovial fluid
 Dialysate Pericardial fluid Middle ear fluid
- WOUND/TISSUE** Tissue Aspirate Swab (suboptimal)
 Specify source _____
- LOWER RESPIR. TRACT** Expectorated sputum Endotracheal aspirate Bronchoalveolar lavage
 Bronchial brush biopsy Transbronchial biopsy Bronchial wash
- UPPER RESPIR. TRACT** Throat swab Nasopharyngeal swab Nasal swab
 Nasopharyngeal wash Sinus Other
- ENVIRONMENTAL SURVEILLANCE** Swab Device Other
 Describe _____
- GENITAL TRACT** Urethral swab Endocervical specimen Vaginal specimen
- STOOL** Feces Rectal swab
- URINE** Mid-stream clean catch Foley catheter
 First void clean catch Other:
 Straight cath specimen
- Other: _____

Medicare will only pay for services that it determines to be reasonable and necessary under section 1862 (a)(1) of the Medicare law.

Procedure(s) Requested: Check the box that corresponds to the procedure(s) requested. More than one box may be checked for a single speci-

MICROBIOLOGY-VIROLOGY-MOLECULAR DIAGNOSTICS LABORATORY REQUISITION

	CULTURES:	DIRECT EXAMS:	SEROLOGY and OTHER TESTS:
BACTERIOLOGY	<input type="checkbox"/> Routine aerobic culture <input type="checkbox"/> Anaerobic culture <input type="checkbox"/> Surveillance culture <input type="checkbox"/> R/O Group A Strep culture <input type="checkbox"/> R/O Group B Strep culture <input type="checkbox"/> R/O <i>N gonorrhoeae</i> culture <input type="checkbox"/> R/O <i>Yersinia</i> culture <input type="checkbox"/> R/O MRSA <input type="checkbox"/> R/O Staph aureus <input type="checkbox"/> <i>C trachomatis</i> culture	<input type="checkbox"/> Gram stain <input type="checkbox"/> <i>Helicobacter</i> CLO test <input type="checkbox"/> <i>C. difficile</i> toxin A & B test <input type="checkbox"/> <i>E. coli</i> Shiga toxin by EIA <input type="checkbox"/> <i>Legionella</i> antigen (Urine) <input type="checkbox"/> Grp B strep antigen (Serum/CSF)	<input type="checkbox"/> <i>Helicobacter</i> IgG antibody <input type="checkbox"/> Lyme IgG/IgM antibody <input type="checkbox"/> <i>Chlamydia trachomatis</i> PCR <input type="checkbox"/> R/O VRE PCR (rectal swab)
MYCOLOGY (Fungus)	<input type="checkbox"/> Routine fungus culture <input type="checkbox"/> Fungus blood culture <input type="checkbox"/> R/O yeast culture	<input type="checkbox"/> Fungal smear (calcofluor) <input type="checkbox"/> Pneumocystis (PCP) detection <input type="checkbox"/> Cryptococcal antigen test (serum/CSF) <input type="checkbox"/> Giemsa (if Histoplasma suspected)	
MYCOBACTERIOLOGY (TB)	<input type="checkbox"/> Routine AFB culture <input type="checkbox"/> AFB blood culture	<input type="checkbox"/> AFB smear	
PARASITOLOGY		<input type="checkbox"/> Routine O & P exam <input type="checkbox"/> Wet prep <input type="checkbox"/> Malaria smear (Giemsa) <input type="checkbox"/> <i>Giardia/Cryptosporidium</i> DFA	<input type="checkbox"/> Toxoplasma IgG antibody <input type="checkbox"/> Toxoplasma IgM antibody
VIROLOGY NOTE: If Avian influenza is suspected, please notify laboratory.	<input type="checkbox"/> Adenovirus culture <input type="checkbox"/> Respiratory viruses culture <input type="checkbox"/> Cytomegalovirus culture <input type="checkbox"/> HSV and/or Varicella-zoster virus culture <input type="checkbox"/> Enteroviruses culture <input type="checkbox"/> HSV PCR (CSF) <input type="checkbox"/> Enterovirus PCR (CSF) <input type="checkbox"/> CMV Quant. PCR	<input type="checkbox"/> All respiratory viruses <input type="checkbox"/> RSV antigen <input type="checkbox"/> Influenza A/B antigen <input type="checkbox"/> Parainfluenza antigen (1,2,3) <input type="checkbox"/> Adenovirus antigen <input type="checkbox"/> Rotavirus antigen <input type="checkbox"/> HSV antigen (lesion only) <input type="checkbox"/> VZV antigen (lesion only)	<input type="checkbox"/> CMV IgG antibody <input type="checkbox"/> CMV IgM antibody <input type="checkbox"/> VZV IgG antibody <input type="checkbox"/> Rubella IgG antibody <input type="checkbox"/> Rubella (measles) IgG antibody <input type="checkbox"/> Mumps IgG antibody

Other

Please specify: _____

By signing on the line below, I'm requesting that any additional testing, not specifically ordered on this requisition, must be preapproved by me. I understand that additional tests will require a new order, signed by me and that this may significantly delay testing.

Requesting Physician Signature Date Time

A-1a
 B CLIN. NOTES
 C LABORATORY
 D X-RAY EXAM
 E CONSULTATION
 F SPEC. EXAM
 G THERAPY
 H PATHOLOGY
 I DIAGNOSIS