ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Connect Care Downtime Microbiology Requisition

Alberta Precision Laboratories 1-877-868-6848

Scanning Label or Accession # *(lab only)*

Important - Form is used for Connect Care downtime use. ***Bold*** and ***italicized*** fields contain critical data elements that must be reconciled for downtime.

Patient

PHN Expiry: ________	Date of Birth *(dd-Mon-yyyy)*	
Legal Last Name	Legal First Name	Middle Name

Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Phone

Address	City/Town	Prov	Postal Code

Provider(s)

Authorizing Provider Name *(last, first, middle)*			Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*
Address		Phone	Address	Address
CC Provider ID	CC Submitter ID	Legacy ID	Phone	Phone
Clinic Name			Clinic Name	Clinic Name

Collection

Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

☐ **Pregnant**
☐ **Immunosuppressed**
☐ **Antimicrobials**
☐ **Clinical Information/Suspected Organism**

Urine

☐ **Urine Culture, Routine**
☐ Midstream ☐ Indwelling Catheter ☐ In/Out Catheter ☐ Other ______

History required

Symptomatic
☐ Lower UTI/cystitis symptoms or signs
☐ Suspect sepsis/pyelonephritis
☐ UTI in MS or neurogenic bladder

Asymptomatic
☐ ***Pregnant***
☐ Prior to invasive urologic procedure
☐ < 1 month post-renal transplant

Respiratory

☐ **Acute Pharyngitis Screen/Culture *(Group A Streptococcus)***, Throat Swab
☐ Allergy to penicillin ☐ Treatment failure ☐ Indeterminate within 7 days

☐ **Sputum Culture**

☐ **Bronchial Culture** ☐ Lavage ☐ Wash (*specify site*) ______________

Wound

☐ **Superficial Wound Culture** (≤2cm)
☐ **Deep Wound Culture** (>2cm)

(must specify body site) ______________
☐ Wound ☐ Ulcer ☐ Bite
☐ Surgical ☐ Abscess ☐ Diabetic

Stool

☐ **C. difficile Test**

☐ **Bacterial Enteric Panel/Stool Culture** *(Salmonella, Shigella, Campylobacter, STEC)*
Provide additional history if testing for additional pathogens is required.
☐ Raw shellfish exposure ☐ Immunocompromised ☐ Symptoms >1 week
☐ Travel or other history *(specify)* ______________________________

☐ **Stool Parasite Screen** *(Giardia/Cryptosporidium)*
Symptom Onset Date *(required)* ____________ Other History____________

Other

☐ **Malaria** Requires Malaria History Form - see Test Directory
☐ **Fungal Culture**
(specify specimen type and body site) ______________________________

Surveillance

☐ **MRSA Screen** ☐ Nasal ☐ Inguinal
☐ **CPO Screen** ☐ Rectal ☐ Stool ☐ Other *(specify)* ______________
☐ **Other ARO (IPC-use only)** *(specify organism and source)* ______________

Additional Tests *(indicate test and source)*

Blood, Fluid and Tissues

☐ **Blood Culture** ☐ Peripheral ☐ Central ☐ Other ____________

☐ **Fluid Culture** ☐ Prosthetic Joint/Periprosthetic
(specify body site) ______________________________
☐ Synovial ☐ Bursa ☐ Aspirate ☐ Drain
☐ Peritoneal ☐ Abdominal ☐ Dialysate ☐ Pleural
☐ Pericardial

☐ **CSF Culture** ☐ LP ☐ EVD ☐ Other *(specify)* ________
☐ **Fungal Culture** *(Includes Cryptococcal antigen)*

☐ **Tissue Culture** ☐ Prosthetic Joint/Periprosthetic
(specify body site) ______________________________

☐ **Bone Culture** ☐ Prosthetic Joint/Periprosthetic
(specify body site) ______________________________

☐ **Bone Marrow Culture** *(specify body site)* ______________

Implanted Devices

☐ **Implanted Medical Device Culture**
(specify body site and device description) ______________________

☐ **Catheter Tip Culture** (*specify*) ______________________

Urogenital - Molecular (Aptima)

☐ Vaginitis Screen, Vaginal Swab (≥14 years only) ***Multitest Swab***
(Bacterial Vaginosis, Candida, Trichomonas vaginalis)

☐ **Chlamydia/Gonorrhea Screen**
History required
☐ Symptomatic/at risk
☐ Prenatal screen
☐ Initial screen
☐ Rescreen
☐ Test of cure

☐ Urine, first-catch
Multitest Swab:
☐ Vagina ☐ Rectum ☐ Throat
Unisex Swab:
☐ Endocervix ☐ Urethra
☐ Left eye ☐ Right eye

☐ **Trichomonas vaginalis Screen**
☐ Vagina ***Multitest Swab***
☐ Endocervix ***Unisex Swab***
☐ Urine, First-Catch

Urogenital - Culture *(ESwab)*

☐ **Group B Streptococcus Screen,** Vaginal/Rectal Swab
☐ Allergy to penicillin