

MICROBIOLOGY REQUISITION

UCSF Medical Center

- UCSF Medical Center
San Francisco, CA
- UCSF/Mount Zion Medical Center
San Francisco, CA
(check hospital location)

CLINICAL LABORATORIES

701-033Z (Rev. 02/07) WorkflowOne

L B S G N	<input type="checkbox"/> VPO <input type="checkbox"/> HS _____ TECH CODE	SPECIMEN COLLECTION	
	RECEIVE	ENTER	Date: _____ Time (24 hour clock): _____
			M.D. # _____ ATTENDING PHYSICIAN'S NAME (PRINT) _____
			M.D. # _____ ORDERING PHYSICIAN'S NAME (PRINT) _____
		M.D. # _____ COPY TO NAME (PRINT) _____	
LABEL	ALIQUOT	Enter phone # & location to call for sample/test problems or panic results: _____	

UNIT NUMBER	_____
PT. NAME	_____
BIRTHDATE	_____
LOCATION	_____
DATE	_____

CLINICAL FINDINGS:

- Immunocompromised host
specify: _____
- Transplant (specify organ): _____
- Antibiotic Rx (specify): _____

Suspected pathogen(s): _____

BUDGET ACCOUNT NO.	_____	Phone #'s for stat/consult UCSF: 353-1268 After 2330 hrs.: 353-1667
ICD-9 CODES (required on outpatients only):		
1. _____	2. _____	3. _____ 4. _____ 5. _____

MEDICAL NECESSITY AND ICD-9 CODES (Required for outpatients only) Medicare (and, increasingly, other insurers) will only pay for services that are reasonable and necessary for the diagnosis and treatment of the patient. The physician must specify an ICD-9 diagnostic code to indicate the medical necessity of each test requested. Medicare and other carriers may not pay for screening tests or tests that are not FDA-approved. If there is reason to believe that a carrier will not pay for a test, the patient should be informed and asked to sign an Advanced Beneficiary Notice (ABN - Attach to requisition) indicating acceptance of responsibility for the cost of the test if the carrier denies payment. Write the ICD-9 diagnosis code(s) for this patient in the numbered spaces above right, then check off the tests desired.

STEP 1: CHECK SPECIMEN SOURCE (1 PER FORM)	STEP 2: CHECK TEST(S) REQUESTED
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URINE: Clean catch midstream
 Screen only: omit I.D. and susceptibility
 First void (Chlamydia)
 Indwelling CATH collect with vacutainer (red top)
 Straight (In & Out) CATH
 Other: _____
(describe)

RESPIRATORY:
 SPUTUM: Expectorated Induced Trach aspirate
 THROAT
 NP wash
 BRONCHOALVEOLAR LAVAGE (BAL) Mini-BAL
 OTHER: _____
(describe)

STERILE SITES: Collected in surgery
 TISSUE (type): _____
 FNA (site): _____
 CSF
 BODY FLUID (type): _____
(Submit >10 ml in capped syringe)
 BLOOD: Peripheral / New Line / Old Line / Rewire
 (MUST check one) Site/line type _____

NON-STERILE SITES:
 STOOL Check if bloody *If unpreserved submit 0700 to 2330*
 CERVIX VAGINAL (site): _____
 WOUND (site): _____
 ABSCESS (site): _____
 TUBE DRAINAGE (site): _____
 CATHETER TIP
 OTHER (site): _____
(describe)

BACTERIAL:

DIRECT EXAM: Gram stain Stat: call to # _____
 Clostridium difficile toxin
 Legionella FA (requires consultation)
 Rapid strep Group A
 Pertussis PCR

CULTURE: Culture includes Gram stain, anaerobic culture and susceptibility test, where site and specimen appropriate. For outpatients: Beta Strep only on throats
 Aerobic only Aerobic & anaerobic
 Omit susceptibility testing Omit full ID
 CF respiratory culture (incl. S. aureus & B. cepacia)
 Gonococci
 Beta-strep
 Legionella culture
 Other (specify): _____

AFB:
 Smear (Routinely run only on tissue, respiratory)
 Culture (includes Nocardia)
 Cultures of CSF, urine, stool, or swabs require consultation.

FUNGAL:

DIRECT EXAM: Cryptococcal Antigen (CSF, serum only)
 KOH exam (not on CSF)

CULTURE: CSF Crypto Culture (antigen more sensitive)
 CSF Cocci Culture (serology more sensitive)
 Routine Fungal Culture (**NOT performed on CSF, swabs, stool, or urine.** Includes KOH when appropriate).
 Yeast (not on sputum or tracheal culture)
 Aspergillus

VIRAL:

DIRECT EXAM: CMV antigen (blood only; submit by 1430)
 Rotavirus antigen
 HSV direct Ag (2 slides required)
 VZV direct Ag (2 slides required)
 Respiratory virus direct antigens: RSV
 Influenza A Influenza B Adeno
 Parainfluenza: 1 2 3 All 7
 Other (specify): _____

CULTURE: Herpes simplex culture
 CMV culture (BAL, biopsies only)
 Enterovirus culture
 Other culture (specify virus): _____

PCR: HSV (CSF, consult required)
 VZV (CSF, consult required)

CHLAMYDIA: DNA detection (cervix, urethral, first 15-20 mL voided urine only)
 Culture for C. trachomatis

PARASITES: Routine Ova and Parasite exam (submit in SAF)
 Trichomonas (Requires In Pouch Kit)
 Microsporidia smear exam
 Giardia EIA Stat: call to # _____
 Malaria exam Stat: call to # _____
 (Provide travel and Rx history above)
 Other: _____

OTHER MICRO TESTS:
 requires consultation _____

MOUNT ZION SPECIMEN DROP OFF:
 400 PARNASSUS AVE., A122
 (415) 353-2736

MICROBIOLOGY

MOUNT ZION SPECIMEN DROP OFF:
 2330 Post St.
 (415) 885-7531