



Patient Name & Address (Print Clearly)	Patient HSN	Provider (Include First Name and Middle Initial)	Provider MSB #
	Date of Birth D / M / Y	Return Address (Provider/Clinic/Hospital)	
	<input type="checkbox"/> Male <input type="checkbox"/> Female	Provider or Lab Phone Number	
	Submitter Phone #	If Additional Copy is Required: <input type="checkbox"/> Fax to Ordering Provider - Fax # _____	
Hospital ID, Ward or Room # <input type="checkbox"/> IN Patient <input type="checkbox"/> OUT Patient	Outbreak #	<input type="checkbox"/> Provider _____ Last Name First Name Initial Fax # _____	
Symptoms	Symptom Onset Date D / M / Y	Address _____	
Diagnosis	Collection Date D / M / Y	City/Prov. _____ Postal Code _____	
Medication	Collection Time H / M		

**Reason for Request**

Prenatal  High Risk  
 Occupational  Immigration/Travel  
 Sexual Assault/Abuse  Other

Details \_\_\_\_\_

**CHOOSE ONE TEST PER SPECIMEN  
USE ONE REQUISITION PER SPECIMEN**

**Respiratory**

**Respiratory Screen (NAAT)**  
Use UTM for respiratory viruses and Pertussis

Nasopharyngeal Swab  Throat Swab  
 Source \_\_\_\_\_

**Bacterial Studies (Culture)**

**Pertussis Culture** [Nasopharyngeal swab in Regan-Lowe Medium]  
 **Diphtheria**  
 **Legionella** } Specimen Source \_\_\_\_\_

**Sexually Transmitted Infections**

**Chlamydia & Gonorrhoea Screen**

Urine Use APTIMA Urine Collection Kit [YELLOW]  
 Vagina  Rectum  Throat  
 Use APTIMA Multitest Swab Specimen Collection Kit [ORANGE]  
 Cervix  Urethra  Eye  
 Use APTIMA Unisex Swab Collection Kit [WHITE]

**Trichomonas**  
 Vagina Use APTIMA Multitest Swab Specimen Collection Kit [ORANGE]

**Ureaplasma/Mycoplasma Culture**  
 Cervix  Urethra  Other:

**Dermatophytes**

Hair  Nails  
 Skin scraping: Site \_\_\_\_\_

Travel/Animal Contact \_\_\_\_\_

**Mycology**

Sputum  Bronchial wash  
 Ear  Eye  Left  Right  
 Fluid, tissue, biopsy, aspirate, specify: \_\_\_\_\_  
 Other, specify \_\_\_\_\_

**CLINICAL INFORMATION (Immunosuppressed, etc.):**

**TB & Mycobacteriology**

Sputum [Optimal Volume is 5 to 10 mL]  
 Bronchial (Specify) \_\_\_\_\_  
 Blood [Mycro/F-Lytic Blood Culture bottles ONLY]  
 CSF  Urine  
 Tissue (Specify) \_\_\_\_\_  
 Sterile fluid (Specify) \_\_\_\_\_  
 Other (Specify) \_\_\_\_\_

**Stool**

Use Stool Container [No Preservative]

Viral Studies  Norovirus  *C. difficile* reference testing  
 Culture (reference testing): organism \_\_\_\_\_  
 *H. Pylori* antigen [Store at 2-8C, frozen if >72 hours]  
 Food Borne Illness Outbreak

**Organisms/Reference Testing**

Bacteria  Yeast  Fungus  
 Confirm ID  Subtype  Susceptibility

**CSF** [Optimal Volume is 2 mL]

HSV PCR- preapproved [Freeze and Ship Frozen]  
 VZV PCR- preapproved [Freeze and Ship Frozen]  
 WNV PCR - preapproved [Freeze and Ship Frozen]  
 Viral Culture [Refrigerate]

**Parasites**

Giardia and Cryptosporidium antigen screen (stool in SAF)  
 Pinworm Exam (paddle preferred)  
 Parasite ID (worms, arthropods, etc.)  
 Scabies (skin scrapings)  
 *Schistosoma haematobium* (urine)  
 Ova & Parasite Exam (stool in SAF)

**Relevant History Required, check all that apply**

Travel/immigration  Age <13 years  
 Country \_\_\_\_\_  Symptoms >2 weeks  
 Dates \_\_\_\_\_  Unsafe food/water  
 Immunosuppressed  Prior parasite:  
 Suspected helminth other than *Enterobius vermicularis* \_\_\_\_\_  
 Case contact  
 Eosinophilia  
 Other \_\_\_\_\_

Specimen Source \_\_\_\_\_

Suspected ID: \_\_\_\_\_

Gram/other stains: \_\_\_\_\_

Growth conditions:  
 O2  CO2  Anaerobic

Comments \_\_\_\_\_

Oxidase: \_\_\_\_\_ Catalase: \_\_\_\_\_ Haemolysis: \_\_\_\_\_

Resistance confirmation (ESBL, CRE etc.): \_\_\_\_\_

Comments \_\_\_\_\_

**Viral Exanthemata**

Mumps  Urine (50 ml min)  Buccal Swab  
 Measles  Nasopharynx  Throat  
 Urine (50ml min)

**Herpes Simplex/Varicella Zoster**

Swab for Lesion Screen [Use UTM]  
 Specimen \_\_\_\_\_

**Urine**

CMV (Cytomegalovirus) [Minimum volume 50 ml]  
 Legionella Antigen Detection

**Other/Special requests**

# Roy Romanow Provincial Laboratory

## Microbiology Requisition

### GENERAL INFORMATION

#### Unique Patient Identifiers:

**Patient Name, Health Services Number (HSN/PHN), and Date of Birth (DOB)** are used to identify specimens. To assist testing and reporting, **HSN and DOB** must be clearly printed on both the Requisition and Specimen.

#### Reporting:

Test results are reported directly to the Return Address listed on the Requisition. To ensure accurate reporting, the Provider's Full Name, Clinic/Hospital Address, and Phone/Fax Number must be clearly printed on the Requisition. All results are sent to the Saskatchewan Laboratory Results Repository and are available electronically via the **eHS Viewer**. If additional paper (Fax or Mail) copies are required, complete the 'Additional Copy' section of the Requisition. Fax Machines must be in a secure location accessible **ONLY** to persons requiring reports.

#### STAT Testing, Outbreak Samples, and Outbreak Numbers:

STAT testing requests must be pre-arranged. Call 306-787-3131 to request approval from the appropriate RRPL section. To assist with identification and testing of **STAT** and **Outbreak Specimens**, flag the shipping tote with a **Yellow Closure Tie** and identify STAT sample within the tote. Upon declaring an Outbreak, the Medical Health Officer or designate should assign an Outbreak Number, as follows: **Health Region** [3 – 4 letter acronym] – **Calendar Year** [4 digits] – **Sequential Number** [3 digits] e.g. **RQHR-2015-001**. Include the Outbreak Number on the Requisition.

### TESTING & SPECIMEN COLLECTION:

For comprehensive information about RRPL Testing and Specimen Collection protocols, see the **RRPL Compendium of Tests**. The **RRPL Compendium of Tests** is now available on-line at: [RRPL-testviewer.ehealthsask.ca/](http://RRPL-testviewer.ehealthsask.ca/)

#### Stool Specimens For Enteric Pathogens

Only submit fresh, loose stools. Formed stools and rectal swabs are **NOT** acceptable specimen types and will not be tested. **Bacterial Studies** or **Parasites** should not be requested for IN Patients who have been hospitalized for longer than 3 days. Some medicines can interfere with testing. If submitting stool for **Bacterial Studies** or **Parasites**, do not take antibiotics or any medicines containing mineral oil, barium, bismuth, magnesium, or kaolin for at least 6 days prior to collection.

#### Chlamydia & Gonorrhoea

The **Chlamydia & Gonorrhoea Screen** is a nucleic acid amplification-based test that has become the standard method of detecting infection with *Chlamydia trachomatis* and/or *Neisseria gonorrhoeae*.

Indicate on requisition if testing for **LGV** is required.

Contact the RRPL to request **APTIMA Collection Kits** that are compatible with **Chlamydia & Gonorrhoea Screen**.

**Chlamydia Culture** is no longer performed at the RRPL.

A separate specimen is to be submitted for **Trichomonas** testing.

#### Pertussis (Whooping Cough)

RRPL offers two options based upon the type of specimen transport medium.

1. Swabs in **UTM** will be tested for Pertussis by NAAT as part of the **Respiratory Screen**.
2. Nasopharyngeal swabs in **Regan-Lowe** medium are required for **Pertussis Culture** to isolate strains for surveillance activities.

#### Fungal Culture (Mycology)

Submit **Skin, Hair** and **Nail** specimens using the **Mycopak Collection Kit**. To order Mycopaks, contact the RRPL.

**Mouth/Throat** swabs and **Stool** specimens are **NOT** acceptable specimen types for Fungal Culture and will not be tested.

#### Drug Resistant Organisms

To submit a MRSA, VRE or ESBL isolate for Provincial Surveillance activities, use the **RRPL Surveillance Strain Submission Form**.

### CONTACT INFORMATION:

#### Roy Romanow Provincial Laboratory (RRPL)

5 Research Drive  
Regina, SK, Canada  
S4S 0A4

#### RRPL Customer Services:

Phone: **306-787-3131**  
Fax: **306-787-9122**  
Email: [SDCL.CustomerServices@health.gov.sk.ca](mailto:SDCL.CustomerServices@health.gov.sk.ca)  
Web: [RRPL-testviewer.ehealthsask.ca/](http://RRPL-testviewer.ehealthsask.ca/)