MIC Laboratory Requisition

UR Medicine – Clinical Microbiology Laboratory
601 Elmwood Ave, Rochester, NY 14642
Phone: (585) 275-7801 **Fax:** (585) 273-1048

1. Complete Required Fields (*)
2. Print **and Sign**
3. Fax to (585) 273-1048

*Request Date: _____ *ID Physician NAME: _____

*Page / Phone: _____ *ID Physician SIGNATURE: _____

*Patient Name: _____

*MR # or DOB: _____

*Culture Number or Collection Date: _____

*Source: _____

*Organism: _____

_____

*Test Requested:

☐ Broth Dilution MIC

☐ Other: _____

*Antibiotic(s) to be Tested: _____

Antibiotic Therapy: _____

Presumptive Diagnosis: _____

Other Information / Special Request:

FOR LAB USE ONLY: **MSR:** *Upon receipt, give requisition to MIC Lab* / **MIC:** *Affix Order # and return to MSR for scanning*