

University of Colorado Hospital
Clinical Laboratory Microbiology Request
 STAT

Patient Identification Label	
Name	_____
MRN	_____
DOB	_____
Date of service	_____

Location _____ SERUM WHOLE BLOOD PLASMA
 Phone _____ URINE BAL NASAL WASH
 Tube Station # _____ CSF GENITAL ORAL
 OTHER _____

Ordering Provider _____ Collection Date _____ Collection Time _____
 Provider Phone _____ Collected by _____

Physicians should only order tests medically necessary for the treatment or diagnosis of the patient. For outpatient services only, enter the appropriate ICD10 Codes which demonstrate the medical necessity of each test ordered (REQUIRED).

Special Instructions, type of infection, suspected organism:

Bacterial Culture (includes anaerobic culture and sensitivity testing where appropriate)	ICD10 Code
LAB8619 <input type="checkbox"/> BLOOD CULTURE Specify site: _____ Includes quantitative culture (pour plates) if paired green top tubes from peripheral and line specimens are received with blood culture sets.	_____
LAB3274 <input type="checkbox"/> ABSCESS/CLOSED WOUND Specify site _____	_____
LAB269 <input type="checkbox"/> BODY FLUID <input type="checkbox"/> Joint/Synovial <input type="checkbox"/> Peritoneal <input type="checkbox"/> Pleural <input type="checkbox"/> Other (specify site) _____	_____
LAB3274 <input type="checkbox"/> BONE MARROW	_____
LAB268 <input type="checkbox"/> CSF <input type="checkbox"/> CSF Shunt	_____
LAB3274 <input type="checkbox"/> CENTRAL VENOUS CATHETER Specify type _____	_____
LAB3274 <input type="checkbox"/> DRAINAGE/OPEN WOUND Specify site _____	_____
LAB3274 <input type="checkbox"/> EAR Specify: <input type="checkbox"/> Drainage <input type="checkbox"/> Tympanocentesis	_____
LAB3274 <input type="checkbox"/> EYE Specify: <input type="checkbox"/> Conjunctiva <input type="checkbox"/> Cornea	_____
LAB3274 <input type="checkbox"/> GENITAL Specify: <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Endometrial <input type="checkbox"/> Placenta <input type="checkbox"/> Prostate <input type="checkbox"/> Uterine <input type="checkbox"/> Vaginal	_____
LAB3277 <input type="checkbox"/> RESPIRATORY Specify: <input type="checkbox"/> Expectorated sputum <input type="checkbox"/> Induced sputum <input type="checkbox"/> Tracheal aspirate <input type="checkbox"/> Bronchial (specify) _____	_____
LAB3274 <input type="checkbox"/> SKIN Specify site _____	_____
LAB8905 <input type="checkbox"/> STOOL GI PCR PANEL PLUS is performed (includes bacterial, parasitic and viral enteric pathogens).	_____
LAB3274 <input type="checkbox"/> TISSUE/BIOPSY Specify site _____	_____
LAB239 <input type="checkbox"/> URINE Specify: <input type="checkbox"/> Clean catch <input type="checkbox"/> Single/straight cath <input type="checkbox"/> Indwelling cath <input type="checkbox"/> Nephrostomy <input type="checkbox"/> Other _____	_____
<input type="checkbox"/> OTHER _____	_____

OTHER CULTURES/EXAMINATIONS	Source/Site (if not indicated above)	ICD10 Code	ICD10 Code
LAB3452 <input type="checkbox"/> AFB Culture (includes concentrated smear on appropriate specimens)	_____	LAB955	<input type="checkbox"/> Ova & Parasite Exam
LAB240 <input type="checkbox"/> Fungus Culture	_____		One or more of the following must apply: Specify _____
LAB3365 <input type="checkbox"/> Fungus Culture for Hair, Skin, Nails	_____		<input type="checkbox"/> Travel or residence in an endemic area (Specify where) _____
LAB3353 <input type="checkbox"/> GC Culture**	_____		<input type="checkbox"/> Immunocompromised host
LAB3276 <input type="checkbox"/> Infection Control Screen	_____		<input type="checkbox"/> Eosinophilia
Organism to screen for: _____			<input type="checkbox"/> Persistent diarrhea with previous negative antigens
LAB3448 <input type="checkbox"/> MRSA Screen Culture	_____		<input type="checkbox"/> Outbreak or Day Care exposure
LAB3449 <input type="checkbox"/> VRE Screen	_____		
LAB3450 <input type="checkbox"/> Yeast Screen (vaginal, oropharyngeal)	_____		
LAB250 <input type="checkbox"/> Gram Stain	_____		
<input type="checkbox"/> Other Microscopic Exam	_____		
LAB1319 <input type="checkbox"/> Giardia/Cryptosporidium Antigen	_____		
LAB927 <input type="checkbox"/> Cryptococcal Antigen Serum (No gel)	_____		
LAB4248 <input type="checkbox"/> Cryptococcal Antigen CSF	_____		

For other PCR testing, refer to "Clinical Lab Molecular Diagnostic Request (LAB20014)"

To order Blood Parasites, see page 2 of this form



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Unless this testing meets an exception under Colorado law, by authorizing this order you understand that Colorado law requires you to inform the patient that (1) you have ordered testing for sexually transmitted infections; (2) the results may be reported to Colorado's health department; and (3) the patient can opt out of testing. Some test results may generate additional testing. Visit **Compliance at <https://www.uhealth.org/professionals/Pages/Clinical-Laboratory.aspx> to see our Reflex Testing Protocols.

ICD10 Code

LAB3267 Blood Parasites _____

Send sample to lab within one hour of collection.

Includes:

- Rapid malarial antigen on initial specimen
- Blood parasite slide exam
- Parasitemia calculation for Plasmodium falciparum and Babesia species only

Please fill out complete details below. Failure to provide necessary information may delay testing.

Patient's travel history _____

Primary admitting diagnosis _____

History of blood parasites? _____

If yes, what species? _____

Is this the initial specimen? _____

Is this a follow-up sample for parasitemia? _____

