MCUCSF SPECIMEN DROPOFF:
400 Parnassus Ave., A122
(415) 353-2736

MICROBIOLOGY

MT ZION SPECIMEN DROPOFF:
2330 Post St.
(415) 885-7531

PROOF VERSION #2 04-18-16

UCSF MICROBIOLOGY REQUISITION

SPECIMEN COLLECTION

Date: ___________ Time: ___________

☐ VPO ☐ HS

Tech code: ___ ___ ___

Rec'd: ___________ Enter: ___________

701-033Z (Rev. 08/12) WorkflowOne

L B S G N

COMPLETE ALL ITEMS IN THIS BOX

Ordering Provider ______________________ UCSF Provider # __ __ __ __ __ (Required)

Provider is a(n): ☐ Attending ☐ Resident/Fellow (attending info. req'd.) ☐ Allied Health Practitioner (Incl. attending info. if req'd.)

Attending Physician ______________________ (Print Name) UCSF Provider # __ __ __ __ __ (Required)

Copy to: ______________________ (Print Name) UCSF Provider # __ __ __ __ __ (Required)

Authorizing Provider Signature: ______________________ (Required)

MRN

PT. NAME

BIRTHDATE SEX

CLINIC DOS

CLINICAL FINDINGS:

Suspected pathogen(s):

☐ Immunocompromised host specify: ______________________

☐ Transplant (specify organ): ______________________

☐ Antibiotic Rx (specify): ______________________

BUDGET ACCOUNT NO.

Phone #'s for stat/consult
UCSF: 353-1268
After 2330 hrs.: 353-1667

ICD-10 CODES (required on outpatients only):

1. ________ 2. ________ 3. ________ 4. ________ 5. ________

MEDICAL NECESSITY AND ICD-10 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-10 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-10 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)

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 Flocked swab
☐ BRONCHOALVEOLAR LAVAGE (BAL) ☐ Mini-BAL
☐ ANTERIOR NARES
☐ OTHER: ______________________ (describe)

STERILE SITES: ☐ Collected in surgery
☐ TISSUE (type): ______________________
☐ FNA (site): ______________________
☐ CSF
☐ BODY FLUID (type): ______________________
☐ BLOOD: (Must check source below)
☐ Peripheral ☐ Central Line
☐ Differential Time to Positivity (Complete info below)
Line: __________ Draw time: __________
Peripheral draw time: __________

NON-STERILE SITES:
☐ STOOL *If unpreserved submit 0700 to 2330*
☐ CERVIX ☐ VAGINAL (site): ______________________
☐ WOUND (site): ______________________
☐ ABSCESS (site): ______________________
☐ TUBE DRAINAGE (site): ______________________
☐ OTHER (site): ______________________ (describe)

701-033Z (Rev. 04/16)

STEP 2: CHECK TEST(S) REQUESTED

BACTERIAL:
☐ Clostridium difficile
☐ Bacterial vaginosis/Yeast Screen
☐ Rapid strep Group A
☐ Pertussis PCR
☐ C. trachomatis/N. gonorrhoeae RNA

Culture includes Gram stain, anaerobic culture and susceptibility test, where site and specimen appropriate.

☐ Bacterial culture
☐ Omit susceptibility testing ☐ Omit full ID
☐ CF respiratory culture (incl. S. aureus & B. cepacia)
☐ Group A Strep culture
☐ Group B Strep culture
☐ Legionella culture ☐ Legionella PCR
☐ MRSA Screen (inpatients/anterior nares only)
☐ Staph. Aureus culture

AFB:
☐ Culture (includes Nocardia)

Cultures of CSF, urine, stool, or swabs require consultation.

FUNGAL:
☐ Cryptococcal Antigen (CSF, serum only)
☐ 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:
☐ Rotavirus antigen
☐ HSV direct Ag (2 slides required)
☐ VZV direct Ag (2 slides required)
☐ Herpes simplex culture
☐ CMV culture (BAL, biopsies only)
☐ Influenza A/B & RSV PCR
☐ Respiratory viral panel PCR
☐ HSV PCR
☐ VZV PCR

PARASITES:
☐ Routine Ova and Parasite exam (submit in SAF)
☐ Trichomonas RNA
☐ Microsporidia smear exam
☐ Giardia EIA
☐ Malaria exam (Provide travel and Rx history above)

OTHER MICRO TESTS:
requires consultation

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