Microbiology Requisition H-445

Only one specimen per form.
Please refer to Test Reference Manual and Fee Schedule for more information:
milwaukee.gov/health/testing-Fees

City of Milwaukee Health Department Laboratory
841 N. Broadway, Room 205, Milwaukee, WI 53202-3653
Phone: (414) 286-3526 FAX: (414) 286-5098
email: mhdlab@milwaukee.gov web: milwaukee.gov/healthlab

PATIENT INFORMATION *(required)*

Last Name: ______________________________

First Name: ______________________________ MI: _____

Date of Birth *(mm/dd/yyyy)*: _____/_____/_______

Street Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________________________

Social Security Number: ______-_______-__________

Sex assigned at birth: ☐ Male (M) ☐ Female (F) ☐ Unknown

Gender: ☐ Male (M) ☐ Female (F) ☐ Transgender (☐ M-to-F) (☐ F-to-M)
☐ Nonconforming ☐ Other: ______________ ☐ Unknown

Race: ☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Native Hawaiian and Other Pacific Islander ☐ Asian ☐ Unknown

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

SPECIMEN TYPE

(Must select one)

☐ Check if patient collected

- ☐ Aptima tube
- ☐ Blood tube
- ☐ Cary-Blair
- ☐ Dry swab
- ☐ E-swab
- ☐ InTray
- ☐ Isolate
- ☐ Sterile container
- ☐ Swab in bacterial transport medium
- ☐ Universal Transport Medium (UTM) swab
- ☐ Viral Transport Medium (VTM) swab
- ☐ Other: ____________________

SPECIMEN SOURCE

(Must select one)

- ☐ Blood
  - ☐ Plasma
  - ☐ Serum
  - ☐ Whole blood
- ☐ Buccal
- ☐ CSF
- ☐ Conjunctival
- ☐ Endocervical
- ☐ Lung
  - ☐ Left
  - ☐ Right
  - ☐ Bilateral
- ☐ Nasal
- ☐ Nasopharyngeal (NP)
- ☐ Oropharyngeal (OP)
- ☐ NP/OP
- ☐ Penile
- ☐ Rectal
- ☐ Spleen
- ☐ Stool
- ☐ Urethral
- ☐ Urine
- ☐ Vaginal
- ☐ Wound location: __________
- ☐ Lesion location: __________
- ☐ Other: __________

Date Collected: _____/______/_________ Time: ______________
mm dd yyyy

Specimen ID# ______________________________

TEST(S) REQUESTED (Check all that apply)

*** Please contact the lab for Select Agent rule-out confirmation ***

Bacteriology (Culture)

- ☐ Enteric Pathogens
  - ☐ Campylobacter
  - ☐ Escherichia coli O157
  - ☐ Salmonella
  - ☐ Shigella
  - ☐ Yersinia enterocolitica
- ☐ Neisseria gonorrhoeae w/AST

Bacteriology (Non-culture)

- ☐ Shiga Toxin

Clinical/Referred Isolate for ID

- ☐ Bacterial

Suspect agent: ____________________

Serology

- ☐ HCV
- ☐ HIV 1/2
- ☐ Syphilis w/reflex RPR, TPPA
  - ☐ RPR (titer) ☐ TPPA (only)

Molecular Testing

- ☐ Bordetella pertussis/parapertussis
- ☐ Chlamydia/Gonorrhea Combo NAAT
- ☐ Herpes Simplex Virus 1/2
- ☐ HCV
- ☐ Measles
- ☐ MPOX
- ☐ Mumps
- ☐ Mycoplasma genitalium NAAT
- ☐ Norovirus (GI & GII)
- ☐ Respiratory Pathogen Panel
- ☐ SARS-CoV-2/Influenza A/B Combo
- ☐ Trichomonas vaginalis NAAT
- ☐ Varicella Zoster Virus
- ☐ Other: ____________________

PATIENT HISTORY/CLINICAL INFO

Clinical Diagnosis: ______________________________

Date of onset: ______ / ______ /__________
mm dd yyyy

Date of death: ______ / ______ /__________
mm dd yyyy

☐ Disease Determination ☐ Other outbreak-related
☐ Surveillance

CARGOS USE ONLY

☐ Test of cure
Contact to: ☐ STI ☐ GC
Urethral discharge: ☐ MSM ☐ MSW
☐ Extra genital collection based on reported sexual activity
☐ NAAT + GC/Treatment
Gender of sex partner(s): ☐ Male ☐ Female ☐ Both

YOUR FACILITY *Enter your facility address. Results are returned to this address.*

Facility Name: ______________________________

Physician ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ____________________ Fax: ____________________

For internal use only