Microbiology Requisition H-445

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

PATIENT INFORMATION *(required)*

Last Name: _____

First Name: _____ MI: _____

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

Street Address: _____

City/State/Zip:_____

Phone:_____

Social Security Number:_____-_____-_____

Gender: ☐M ☐F ☐M→F ☐F→M ☐Other

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

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

SPECIMEN TYPE

Check appropriate specimen and fill in requested information.

☐Body Fluid Specify: _____
☐Bronchial wash
☐Lesion
☐Wound Specify: _____
☐Sputum
☐Stool
☐Respiratory Swab Specify: _____
☐STI Swab (Genital) Specify: _____
☐Patient-collect
☐STI Swab (Non-Genital) Specify:_____
☐Patient-collect
☐Tissue Specify: _____
☐Urine
☐Other Specify: _____

Date Collected: _____/_____/_____ Time:_____
mm dd yyyy

Specimen ID# _____

TEST(S) REQUESTED *Check all that apply.*

Bacteriology (Culture)
☐Chlamydia sp
☐Legionella pneumophila
☐Mycoplasma hominis
☐Ureaplasma urealyticum
☐Neisseria gonorrhoeae w/AST
☐Enteric Pathogens
☐Campylobacter
☐Escherichia coli O157:H7
☐Salmonella
☐Shigella
☐Yersinia enterocolitica

Clinical/Referred Isolate for ID
☐Bacterial ☐Fungal

Suspect agent: _____

Rule out
☐ Mpox
☐ B. Anthracis

Parasitology
☐Acanthamoeba
☐Cryptosporidium & Giardia
☐Cyclospora
☐Cystoisospora (Isospora)
☐Microsporidia
☐Ova & Parasite Exam
Suspect agent:_____

Serology
EIA
☐HIV 1/2
☐Shiga Toxin
☐Syphilis w/reflex RPR,TPPA
☐RPR (titer) ☐TPPA (only)

DNA Sequencing: ☐Bacterial ID
☐Fungal ID

Molecular Testing
☐Chlamydia/Gonorrhea Combo NAAT
☐Herpes Simplex Virus 1/2
☐Mycoplasma genitalium NAAT
☐Trichomonas vaginalis NAAT

☐Bordetella pertussis/parapertussis
☐Enterovirus
☐Legionella pneumophila
☐Mycobacterium tuberculosis/RIF
☐Respiratory Pathogen Panel
☐SARS-CoV-2/Influenza A/B Combo

☐Gastrointestinal Pathogen Panel
☐Measles
☐Mumps
☐Norovirus (GI & GII)
☐Varicella Zoster Virus
☐Orthopox (Virus)
☐Other:_____

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

PATIENT HISTORY/CLINICAL INFO

Clinical Diagnosis:_____

Date of onset: _____ / _____ /_____
mm dd yyyy

Date of death: _____ / _____ /_____
mm dd yyyy

☐Disease Determination ☐Other outbreak-related
☐Surveillance

SURRG 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