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)*: _____/_____/_____

Social Security Number:_____-_____-_____

Street Address: _____

City/State/Zip:_____

Phone:_____

Gender: ☐M ☐F ☐M→F ☐F→M ☐Other

Race: ☐White ☐Black ☐Native Hawaiian/Pacific Islander
☐Native American/Native Alaskan ☐Asian ☐Unknown

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

SPECIMEN TYPE

Check appropriate specimen and fill in requested information.

☐Blood
☐Body Fluid Specify: _____
☐Bronchial wash
☐Lesion
☐Wound Specify: _____
☐Sputum
☐Stool
☐Swab (Genital) Specify: _____
☐Patient-collect
☐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)
☐Campylobacter
☐Chlamydia trachomatis
☐Escherichia coli O157:H7
☐Legionella
☐Mycobacterium
☐Mycoplasma hominis
☐Neisseria gonorrhoeae w/AST
☐Salmonella
☐Shigella
☐Ureaplasma urealyticum
☐Yersinia enterocolitica

Enteric Pathogens
☐Campylobacter
☐Escherichia coli O157:H7
☐Salmonella
☐Shigella
☐Yersinia enterocolitica

Clinical/Referred Isolate for ID
☐Bacterial ☐Viral
☐Fungal
☐Mold ☐Yeast
Suspect agent: _____

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

Serology
EIA
☐HIV 1/2 ☐Measles IgG
☐Mumps IgG ☐SARS-CoV-2 IgG
☐Shiga Toxin
☐Syphilis w/reflex RPR, TPPA
☐RPR (titer) ☐TPPA (only)

Molecular Testing
☐Chlamydia/Gonorrhea Combo NAAT
☐Mycoplasma genitalium NAAT
☐Trichomonas vaginalis NAAT
☐Gastrointestinal Pathogen Panel
☐Respiratory Pathogen Panel
☐SARS-CoV-2 NAAT

PCR
☐Bordetella pertussis/parapertussis
☐Clostridium difficile
☐Enterovirus
☐Herpes Simplex Virus 1/2
☐Influenza A/B
☐Legionella pneumophila
☐Measles
☐Mumps
☐Mycobacterium tuberculosis/RIF
☐Norovirus (GI & GII)
☐Rubella
☐Varicella Zoster Virus
☐Other: _____

DNA Sequencing: ☐Bacterial ID
☐Fungal ID

DNA Probe: ☐Blastomyces dermatitidis
☐Coccidioides imitis
☐Histoplasma capsulatum

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

PATIENT HISTORY/CLINICAL INFO

Clinical Diagnosis:_____

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

☐Surveillance ☐Disease Determination

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

OTHER SIGNIFICANT FACTORS

☐Animal contact
☐Arthropod contact
☐Foodborne risk
☐Immunocompromised
☐Occupational risk
☐Test of cure
☐Travel
☐Waterborne risk
☐Other outbreak-related

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

Facility Name: _____

Physician _____

Address: _____

City/State/Zip:_____

Phone:_____ Fax: _____

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