

**Louisiana State University Health Sciences Center  
Medical Center of Louisiana at New Orleans**

**MICROBIOLOGY**

Admitting Use Only	Date: _____ Time: _____ Physician's Name (please print): _____ Beeper: _____ Service: _____ Physician's Signature: _____
<p><b>Note: Diagnosis must be printed by each set of laboratory orders.</b></p> <p><b>You must indicate a specimen source for each test required.</b></p>	
<p><b>Bacteriology diagnosis?</b></p> <hr/> <p><b>Specimen Source?</b></p> <p><input type="checkbox"/> Routine (Aerobic) Culture    <input type="checkbox"/> Gram Stain <b>Two swabs are needed for culture and stain</b></p> <hr/> <p><input type="checkbox"/> Gram Stain Only</p> <hr/> <p><input type="checkbox"/> Anaerobic &amp; Aerobic Culture &amp; Gram Stain <b>Two swabs are needed for culture and stain. Must be in anaerobic transport tube or vial</b></p> <hr/> <p><input type="checkbox"/> Group B Strep Only    <input type="checkbox"/> Vag/Cx    <input type="checkbox"/> Vag/ Rectal</p> <hr/> <p><input type="checkbox"/> Group B Strep &amp; Gonorrhea <input type="checkbox"/> Vag/Cx    <input type="checkbox"/> Oral    <input type="checkbox"/> Rectal    <input type="checkbox"/> Penile</p> <hr/> <p><input type="checkbox"/> Gonorrhea Only    <input type="checkbox"/> Vag/Cx    <input type="checkbox"/> Oral    <input type="checkbox"/> Rectal    <input type="checkbox"/> Penile</p> <hr/> <p><input type="checkbox"/> Respiratory Culture &amp; Gram Stain    Source? _____</p> <hr/> <p><input type="checkbox"/> Blood Culture    Site? _____</p> <hr/> <p><input type="checkbox"/> Throat Culture</p> <hr/> <p><input type="checkbox"/> Stool Culture    <input type="checkbox"/> Stain for WBCs</p> <hr/> <p><input type="checkbox"/> Urine Culture</p> <hr/> <p><input type="checkbox"/> CSF Routine Culture and Gram Stain</p> <hr/> <p><input type="checkbox"/> Latex Meningitis Screen</p> <hr/> <p><input type="checkbox"/> Wet Prep (vaginal swab in 0.5ml saline)</p> <hr/> <p><input type="checkbox"/> Occult Blood (stool)</p> <hr/> <p><b>Parasitology diagnosis?</b></p> <hr/> <p><input type="checkbox"/> Ova and Parasites</p> <hr/> <p><input type="checkbox"/> Clostridium difficile toxin (Stool Only)</p> <hr/> <p><input type="checkbox"/> Malaria Smear: 1 purple top</p> <hr/> <p><input type="checkbox"/> Pneumocystis (PCP) Stain    Source? _____</p> <hr/> <p><input type="checkbox"/> Pinworm Prep</p>	<p><b>Virology diagnosis?</b></p> <p><b>Specimen source?</b></p> <p><input type="checkbox"/> Viral Culture</p> <p>Circle suspected virus: CMV HSV Entero. VZ RSV Influenza Adeno Parainfluenza Other: _____</p> <p><input type="checkbox"/> CMV Shell Vial (*Not performed on stool)</p> <p>*Blood must be in green top tube *Body fluids and aspirates in sterile container *Swab in viral transport medium</p> <p><input type="checkbox"/> Chlamydia Culture    <input type="checkbox"/> Oral    <input type="checkbox"/> Genital    <input type="checkbox"/> Rectal *Sexual Assault Only    *Swab in Chlamydia culture medium</p> <hr/> <p><b>FA - Fluorescent Antibody Stain</b>    Source? _____</p> <p>*Blood, body fluids and stools are not acceptable</p> <p><input type="checkbox"/> Chlamydia FA-AG    <input type="checkbox"/> Cytomegalovirus FA-AG</p> <p><input type="checkbox"/> Herpes Simplex FA-AG    <input type="checkbox"/> Varicella-Zoster FA-AG</p> <p><input type="checkbox"/> Legionella FA-AG (Respiratory Specimen Only)</p> <p><input type="checkbox"/> Respiratory Panel FA-AG    Select panel <b>OR</b> individual agent:</p> <p style="padding-left: 40px;"><input type="checkbox"/> Chlamydia    <input type="checkbox"/> Adenovirus    <input type="checkbox"/> RSV</p> <p style="padding-left: 40px;"><input type="checkbox"/> Influenza A    <input type="checkbox"/> Influenza B</p> <p style="padding-left: 40px;"><input type="checkbox"/> Parainfluenza 1    <input type="checkbox"/> Parainfluenza 2    <input type="checkbox"/> Parainfluenza 3</p> <hr/> <p><input type="checkbox"/> Rotavirus (Stool only)</p> <hr/> <p><b>Serological Titer (Red Top Tube of Blood only)</b></p> <p><input type="checkbox"/> Acute    <input type="checkbox"/> Convalescent (collected 10-14 days after acute)</p> <p><input type="checkbox"/> Chlamydia trachomatis IgG    <input type="checkbox"/> Varicella-Zoster IgG</p> <p><input type="checkbox"/> EBV-VCA    <input type="checkbox"/> IgG    <input type="checkbox"/> IgM</p> <hr/> <p><b>TB / Mycology diagnosis?</b></p> <hr/> <p>AFB Blood Culture (*Green Top Tube)</p> <p><input type="checkbox"/> AFB Culture &amp; Smear    Source? _____</p> <p><input type="checkbox"/> Fungal Blood Culture (*Green Top Tube)</p> <p><input type="checkbox"/> Fungal Culture &amp; KOH    Source? _____</p> <p><input type="checkbox"/> Fungal CSF Culture &amp; India Ink</p> <p><input type="checkbox"/> India Ink Only (CSF Only)</p> <p><input type="checkbox"/> KOH Prep Only    Source? _____</p> <p><input type="checkbox"/> Cryptococcal Antigen - Blood (*Red Top Tube)</p> <p><input type="checkbox"/> Cryptococcal Antigen - CSF</p>