

Client Information	<b>MICROBIOLOGY</b> WCP Laboratories, Inc.		Specimen Accession#
	 2326 Millpark Drive Maryland Heights, MO 63043-3530 (314) 991-4313 • Fax (314) 991-4317	Results: <input type="checkbox"/> fax <input type="checkbox"/> phone <input type="checkbox"/> mail	
		Submitting Physician	Date of Collection

PATIENT INFORMATION		PAYMENT INFORMATION	
Last Name	First Name	MI	
Street Address		City, State	Zip Code
Patient Telephone #	Date of Birth (MM/DD/YYYY)	Patient Signature	
SSN	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other	
<b>BILL TO:</b> <input type="checkbox"/> Insurance <input type="checkbox"/> Patient <input type="checkbox"/> Medicare <input type="checkbox"/> Client <input type="checkbox"/> Medicaid <input type="checkbox"/> Other	Insurance Company & Address	Group #	Patient Ins. ID #
		Medicare #	Medicaid #
PLEASE ATTACH INSURANCE CARD COPY		Last Name of Guarantor	First Name
I have read and understand the ABN on reverse side. Patient Initials _____		SSN	DOB

TESTS REQUESTED			
# of specimens _____		ICD-9 Codes: _____	
<input type="checkbox"/>	Culture, Aerobic/Routine	<input type="checkbox"/>	Culture, Body Fluid
<input type="checkbox"/>	Culture, Anaerobic	<input type="checkbox"/>	Culture, Tissue
<input type="checkbox"/>	Gram Stain ONLY	<input type="checkbox"/>	Culture, Group B Streptococcus
<input type="checkbox"/>	Culture, Fungus	<input type="checkbox"/>	Culture, Throat
<input type="checkbox"/>	Smear Only, Fungus / KOH	<input type="checkbox"/>	Culture, Other
<input type="checkbox"/>	Culture, AFB	<input type="checkbox"/>	MRSA Screen
<input type="checkbox"/>	Smear Only, AFB	<input type="checkbox"/>	Urinalysis
<input type="checkbox"/>	Other _____	<input type="checkbox"/>	Culture, Urine

Refrigerate urine not collected in gray top tubes w/ preservative. Store all other specimens at room temperature.

**URINE**

Collection Type:

First Morning Void

Bladder Wash

Voided Urine

Cath Urine

Please supply the following information for complete evaluation		
CLINICAL HISTORY: Pre-Op Diagnosis: _____		Post-Op Diagnosis: _____
Current Antimicrobial Therapy _____		Suspect Agent _____
<b>Specimen Site</b>	<b>Type of Procedure</b>	<b>Clinical Diagnosis</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Additional information: _____		

FOR QUALITY RESULTS, SEND TISSUE AND FLUIDS TO MICROBIOLOGY WHEN AVAILABLE.  
 DO NOT ADD FIXATIVE TO MICROBIOLOGY SPECIMENS.