



REQUISITION FOR STREPTOCOCCUS PNEUMONIAE MOLECULAR DETECTION AND SEROTYPING BY PCR

Streptococcus and STI Section

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SENDER INFORMATION		SPECIMEN INFORMATION	
NAME:		SPECIMEN REF #:	
ADDRESS:		SOURCE OF SPECIMEN*:	
CITY:		COLLECTION DATE (YYYY-MM-DD):	
PROVINCE:	POSTAL CODE:	SPECIMEN TYPE:	EXTRACTED DNA
TELEPHONE:	FAX:	□ CSF □ FLUID	☐ BLOOD ☐ OTHER
EMAIL:		TEST REQUESTED	OTHER
		Select all that apply:	
PATIENT INFORMATION		PCR DETECTION DIRECT FROM CLINICAL MATERIAL	
DATE OF BIRTH (YYYY-MM-DD):		PCR DETECTION OF STREPTOCOCCUS PNEUMONIAE	
SEX		☐ PCR SEROTYPING OF STREPTOCOCCUS PNEUMONIAE ¹	
		CONFIRMED POSITIVE BY:	
		Cp/Ct:	
COMMENTS			