



REQUISITION FOR *STREPTOCOCCUS PNEUMONIAE* MOLECULAR DETECTION AND SEROTYPING BY PCR

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SENDER INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____

PROVINCE: _____

POSTAL CODE: _____

TELEPHONE: _____

FAX: _____

EMAIL: _____

PATIENT INFORMATION

DATE OF BIRTH (YYYY-MM-DD): _____

SEX M F

CITY: _____

SPECIMEN INFORMATION

SPECIMEN REF #: _____

SOURCE OF SPECIMEN*: _____

COLLECTION DATE (YYYY-MM-DD): _____

SPECIMEN TYPE:

EXTRACTED DNA

CSF

BLOOD

FLUID _____

OTHER _____

TEST REQUESTED

Select all that apply:

PCR DETECTION DIRECT FROM CLINICAL MATERIAL

PCR DETECTION OF *STREPTOCOCCUS PNEUMONIAE*

PCR SEROTYPING OF *STREPTOCOCCUS PNEUMONIAE*¹

CONFIRMED POSITIVE BY: _____

Cp/Ct: _____

COMMENTS