Microbiology Send Out Form

Patient isolate/specimen origination:

☐ **Pathology Associates Medical Laboratories**

☐ **Providence Holy Family Hospital**

☐ **Providence Sacred Heart Medical Center**

Date:

Patient Name:

Accession number:

Source:

Send to:

Test Requested:

Select test or free text:

Shipping requirements

☐ Category A ☐ Category B

Remarks:

Form completed by:

Print Form

PLEASE FAX COPY OF REPORT TO:

Sacred Heart Microbiology Department
FAX: 509-474-4411