



**Bill to Submitter/Client**  
(Submitting Facility is Responsible for Payment)



Children's Hospital Colorado

**Children's Hospital Colorado**  
**Department of Pathology & Laboratory Medicine**  
**Microbiology Lab Requisition**  
**Phone (720) 777-6711**  
**Fax (720) 777-7118**

**Specimen Shipping Address:**  
Children's Hospital Colorado  
Clinical Laboratory - Room B0200  
13123 E. 16th Ave  
Aurora, CO 80045

**FAILURE TO COMPLETE BELOW FIELDS WILL DELAY RESULTS**

**\*\*\*PLEASE PROVIDE COMPLETE BILLING INFORMATION\*\***

**Contact Information**

<b>Submitting Institution Name (Submitter)</b>		<b>Submitting Institution Address</b>	
		Street	
		City, State, Zip	
		Phone	Result Fax
<b>Client Specimen Label (if available)</b>		<b>Internal Specimen Label</b>	

**Patient Information**

Last Name	First Name	Middle I	Birthdate (MM/DD/YYYY)	Sex
Ordering Provider (Last, First, and Middle Initial)	Ordering Provider Phone	ICD10/Diagnosis	Ordering Provider NPI	

**Microbiology Specimen Information**

Date Collected (MM/DD/YY) _____	<input type="checkbox"/> Serum	<input type="checkbox"/> Nasal Wash	<input type="checkbox"/> Other
	<input type="checkbox"/> Plasma	<input type="checkbox"/> BAL	
Time Collected (HHMM) _____ AM / PM	<input type="checkbox"/> Stool	<input type="checkbox"/> Swab Source & Site:	<b>Infection and/or Organism Expected:</b>
	<input type="checkbox"/> Urine		

**FAILURE TO COMPLETE WILL DELAY RESULTS**

**Bill To:**  **Billing Facility and Address same as Submitter Listed**

<b>Billing Contact Information:</b>	<b>Billing Facility and Address are DIFFERENT than Submitter Listed, Bill To:</b>
<b>Name:</b>	Institution Name:
<b>Email:</b>	Address (incl City, State, Zip):
<b>Phone:</b>	Phone: Fax:

**Additional comments regarding specimen or testing requested:**

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**Microbiology Lab Test Information - Ordering laboratory is responsible for accuracy of test selection**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Adenovirus PCR Qual (LAB6342)      | <input type="checkbox"/> CMV PCR Quant (LAB7321)                             | <input type="checkbox"/> GI Path Panel (LAB6958)                     | <input type="checkbox"/> MEP Panel PCR (LAB7329)          |
| <input type="checkbox"/> Adenovirus PCR Quant (LAB7431)     | <input type="checkbox"/> CT and NG PCR (LAB7166)                             | <input type="checkbox"/> GI Path Panel <b>with no</b> Diff (LAB8434) | <input type="checkbox"/> MRSA PCR (LAB7591)               |
| <input type="checkbox"/> BK Virus PCR Quant (LAB9584)       | <input type="checkbox"/> EBV PCR Quant (LAB7322)                             | <input type="checkbox"/> HHV6 PCR Quant (LAB7430)                    | <input type="checkbox"/> Respiratory Path Panel (LAB5595) |
| <input type="checkbox"/> C. difficile Toxin B PCR (LAB5736) | <input type="checkbox"/> Enterovirus PCR Qual (LAB4299)                      | <input type="checkbox"/> HSV PCR (LAB5891)                           | <input type="checkbox"/> SARS CoV-2 (LAB9100)             |
| <input type="checkbox"/> CF Path Culture - Throat (LAB4093) | <input type="checkbox"/> Enterovirus & Parechovirus Multiplex PCR (LAB10040) |  | <input type="checkbox"/> VZV PCR (LAB6621)                |

By submitting this requisition you agree to the standard terms and agreements of Children's Hospital Colorado, to obtain a copy of these please reach out to [LabClientServices@childrenscolorado.org](mailto:LabClientServices@childrenscolorado.org)

Please visit our website ([www.childrenscolorado.org/labrequisitions](http://www.childrenscolorado.org/labrequisitions)) regularly to obtain our most current requisition.