

# Clinical Laboratory Order Form - Microbiology Services



Clongen Laboratories, LLC  
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Date:

**Ordered By**

Physician's Name:

Address 1:

Address 2:

City, State, Zip:

Phone:  Fax:

email:

**Patient Information**

Name:

Date of Birth:

Address 1:

Address 2:

City, State, Zip:

Phone:  Fax:

email:

Contact Name:

**Medical History (optional)**

Name of Disease:

Date of Treatment:

**Specimen Type (Please check Box)**

- Whole Blood (purple-top (EDTA) tube)
- Wound (List source)
- Urine
- Sputum
- Swab
- Semen
- Cerebrospinal Fluid (CSF)
- Other:

**Please Select Requested Tests**

- Routine Culture and Identification (Bacteria) \$175
- Blood Culture and Identification (Bacteria) \$225
- Stool Ova and Parasite Examination \$175
- Culture for Fungi and Yeast - Identification \$200
- Whole Blood Wet Mount Examination \$195

Antimicrobial Sensitivity Charges apply only if the test is performed

**Payment Method:**  Credit Card

Check

Card Number:

Expiration Date:

Cardholder Name:

Check #

Amount \$

**Signed By**

**Internal Use Only**

Payment Received:  CC  Check

Order Completed:

Report Date:

Accession #