

Height \_\_\_\_\_ cm      Weight \_\_\_\_\_ kg

Allergies \_\_\_\_\_

<b>Pleural Fluid Specimen Diagnostic Order Set</b>		M	K	O
Orders Processed Date (dd/mm/yyyy)	<input type="checkbox"/> <b>Consent obtained</b> <input checked="" type="checkbox"/> <b>Specimen Source:</b> _____			
Time (hhmm)	<b>Lab Investigations</b> <b>Lab Investigations – Pleural fluid</b> <input checked="" type="checkbox"/> Cell count and differential <input checked="" type="checkbox"/> Glucose <input checked="" type="checkbox"/> Lactate Dehydrogenase <input checked="" type="checkbox"/> Protein <input checked="" type="checkbox"/> Culture <input checked="" type="checkbox"/> Cytology <input type="checkbox"/> Cytology requisition completed			
By	<b>Lab Investigations – Blood/Serum (if not already done on same day)</b> <input checked="" type="checkbox"/> Glucose <input checked="" type="checkbox"/> Lactate Dehydrogenase <input checked="" type="checkbox"/> Protein <input type="checkbox"/> Please run on prior sample if able			
Status	<b>Additional Investigations – Pleural Fluid</b> <input type="checkbox"/> pH <input type="checkbox"/> Immunophenotyping <input type="checkbox"/> Immunophenotyping/flow cytometry requisition completed <input type="checkbox"/> AFB and mycobacterial culture <input type="checkbox"/> Amylase <input type="checkbox"/> Cholesterol <input type="checkbox"/> Triglycerides <input type="checkbox"/> Additional Labs: _____			
Processing Reviewed by				
Status				
Faxed by				
<b>Diagnostics</b> <input type="checkbox"/> CXR PA and Lateral (to be done post thoracentesis)				
<b>Additional Orders</b> _____ _____				

Telephone Order \_\_\_\_\_  
 Ordering Practitioner, Designation      Signature      Date/Time (dd/mm/yyyy hhmm)

If Telephone Order \_\_\_\_\_  
 Ordering Physician      Date (dd/mm/yyyy)      Time (hhmm)       Read Back



**Chart Copy – Do Not Destroy**