niagarahealth
Extraordinary Caring. Every Person. Every Time.

PATIENT INFORMATION

Height _____ cm Weight _____ kg

Allergies _____

		M	K	O
	Synovial Fluid Specimen Diagnostic Order Set			
Orders Processed Date (dd/mm/yyyy)	☐ Consent obtained ☒ Please specify: ☐ Prosthetic joint **OR** ☐ Native joint ☐ Specimen Source: _____ ☐ Site: _____			
	Lab Investigations			
Time (hhmm)	**Lab Investigations – Synovial fluid** ☒ Cell count and differential ☒ Culture ☐ Crystals			
By	***Please ensure that synovial fluid is sent to the lab in a universal sterile container. Please do not send swabs***			
Status	☐ Additional Labs: _____			
	Additional Orders			
Processing Reviewed by				
Status				
Faxed by				

☐ Telephone Order _____ _____ _____

Ordering Practitioner, Designation Signature Date/Time (dd/mm/yyyy hhmm)

If Telephone Order _____ _____ _____ ☐ Read Back

Ordering Physician Date (dd/mm/yyyy) Time (hhmm)

Rev. 11/2017/V1 ORD241

Chart Copy – Do Not Destroy

PatientOrderSets