MercyOne North Iowa Medical Center
1000 4th St Sw • Mason City, Iowa 50401 • Ph.: (641) 428-7494
Laboratory – Microbiology Department

Reference Lab
Bacterial ID (MCID) Form

Reference Lab Name:

Phone:

FAX FORM DIRECTLY TO MERCYONE MICROBIOLOGY: 641-428-6963

PATIENT IDENTIFICATION

Name: _____
(Last) (First) (Middle Initial)

Date of Birth: Age: Sex:

Date Specimen was Collected: Mo_____ Day_____ Yr_____

Source of Specimen (Specify site):_____

Date Isolate Sent: Mo_____ Day_____ Yr_____

Organism Suspected: _____

Isolate Gram Stain Results: _____

Quantity Isolated (1+, 2+, 3+, 4+):_____

Media Isolate Submitted On: _____

Laboratory Examination(s) Requested: **(√) all that apply**

☐ **Identification** ☐ **MIC** (Susceptibility will be performed at an additional charge)

Additional Comments:_____

_____