

Five Valleys Urology

Urinalysis Form

Place Patient Label Here

Date: _____

Time: _____

Provider: _____

Please Complete (Patient)

Phone # to call with results: _____

May we leave a message? no yes

When was sample collected? _____ Has sample been refrigerated? no yes Recheck? _____

If we need to provide a prescription, what is your pharmacy? _____

SUBJECTIVE:

Pain with urination? no yes Duration of pain: <1 day 1-3 days 4-7 days >7 days

If painful urination, what is the severity of the pain (1-10 w/ 10 being most severe)? _____

Improved with medications? no yes none tried If yes, which ones? _____

Are you experiencing foul smelling urine? no yes Blood in urine? no yes

Any fevers, sweats, or chills? no yes Nausea, vomiting, or diarrhea? no yes

To be completed by Five Valleys Urology

OBJECTIVE:

Urine sample obtained, see sheet for UA results

IMPRESSION: _____

PLAN:

No evidence of urinary tract infection Send urine for culture

Start empiric antibiotic therapy:

Ciprofoxacin 500mg PO BID x _____ days

Bactrim DS PO BID x _____ days

Macrobid 100mg PO BID x _____ days

Other: _____

Rx sent by: _____

Date Rx sent: _____

Date patient notified: _____

SIGNED: _____

DATE: _____