Five Valleys Urology

Urinalysis Form (UA Drop-Off)

Place Patient Label Here Date: Time:

Provider at our office:

**Please Complete**

Phone # to call with results: May we leave a message? [ ] no [ ] yes

When was sample collected? Has sample been refrigerated? [ ] no [ ] yes

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

**REASON FOR LEAVING SAMPLE**:

**[ ]Urine check prior to office procedure [ ]Urine check post antibiotics [ ]Cytology**

**[ ]Feeling of UTI:**

* *if YES, please complete the following questions:*

Are you having pain with urination? [ ] no [ ] yes Duration of pain: [ ] <1 day [ ] 1-3 days [ ] 4-7 days [ ] >7

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 going to the bathroom frequently [ ] no [ ] yes If yes, how often?

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

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***To be completed by Five Valleys Urology Physician***

**OBJECTIVE:**

Urine sample obtained, see sheet for UA results

**IMPRESSION/Diagnosis:**

[ ] **Abnormal findings** (Check if Yes)

**PLAN:**

[ ] No evidence of urinary tract infection [ ] Send urine for culture

[ ] Start empiric antibiotic therapy:

[ ] Cipro 500mg PO BID x\_\_\_\_\_\_ days

Rx sent by: \_\_\_\_\_\_\_\_\_\_\_\_

Date Rx sent: \_\_\_\_\_\_\_\_\_\_

Date patient notified:

[ ] Bactrim DS PO BID x\_\_\_\_\_ days

[ ] Macrobid 100mg PO BID x\_\_\_\_\_ days

[ ] Other:

Physician Signature: DATE: