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

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: ____________________________