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

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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:_______________
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