MINISTRY OF HEALTH
KAMUZU CENTRAL HOSPITAL

MICROBIOLOGY REQUEST FORM

Place Barcode sticker here

Patient Name	National Health Identification No:	Date of Birth/Age:	Sex: ☐F ☐M

Ward/ Dept:	Specimen type:	Date of collection	Time of collection	Date of Admission	Specimen Collected By (Name):

Clinical information/ History;	Antimicrobials given prior to admission: ☐ yes ☐ no Currently on antimicrobial therapy: ☐ yes ☐ no
HTC Outcome:	Current Antimicrobial: Start Date:
Requesting Clinician (Name):	Contact: Signature:
Test Requested: ☐ Sterile Fluid analysis ☐ Culture/sensitivity ☐ AAFB	
Specimen Receipt Date & Time:	

FOR LABORATORY USE ONLY

MICROSCOPY/CHEMISTRY: CSF and other primarily sterile body fluids

W. B. C: /cu.mm	Gram Stain Reaction	Gram stain Morphology	India Ink: ☐ Positive ☐Negative
R. B. C /cu.mm	☐ Gram-positive	☐ Cocci ☐ Diplococci	AAFB: ☐ Positive ☐No AAFB seen
Lymphocytes: %	☐ Gram Negative	☐ Bacilli ☐ Cocco-bacilli	Glucose:
Neutrophils %	☐ Gram Variable	☐ Yeast ☐ Other…….	Protein:

Wet Mount:

CULTURE

☐ Not done	☐ No growth of Microorganism	☐ Isolated microorganism (species identification):

ANTIBIOTIC SUSCEPTIBILITY TESTING

Antibiotic	**Zone**					**Zone**							
Amoxillin		R	I	S	Ciprofloxacin		R	I	S	Piperacillin/Tazobactam	☐ S	☐ I	☐ R
Amoxicillin/ Clavulanate		R	I	S	Clindamycin		R	I	S	Tetracycline	☐ S	☐ I	☐ R
Ampicillin		R	I	S	Erythromycin		R	I	S	Trimethoprim/ Sulphamexazole	☐ S	☐ I	☐ R
Ampicillin/Salbactam		R	I	S	Gentamicin		R	I	S	Vancomycin	☐ S	☐ I	☐ R
Ceftazidime		R	I	S	Naladixic acid		R	I	S	Others;	☐ S	☐ I	☐ R
Ceftriaxone/Cefotaxime		R	I	S	Oxacillin		R	I	S		☐ S	☐ I	☐ R
Cefuroxime		R	I	S	Penicillin		R	I	S	**Other techniques:**			
Chloramphenicol		R	I	S	Piperacillin		R	I	S				

Comments:

Analyzed By:	Signature:	Date & Time:	
Authorized By:	Signature:	Date & Time:	