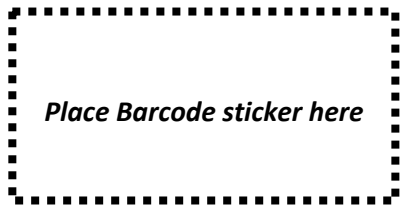




**MINISTRY OF HEALTH
KAMUZU CENTRAL HOSPITAL
MICROBIOLOGY REQUEST FORM**



Patient Name		National Health Identification No:		Date of Birth/Age:	Sex: <input type="checkbox"/> F <input type="checkbox"/> 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: <input type="checkbox"/> yes <input type="checkbox"/> no		
			Currently on antimicrobial therapy: <input type="checkbox"/> yes <input type="checkbox"/> no		
HTC Outcome:			Current Antimicrobial:		Start Date:
Requesting Clinician (Name):			Contact:		Signature:
Test Requested: <input type="checkbox"/> Sterile Fluid analysis <input type="checkbox"/> Culture/sensitivity <input type="checkbox"/> AAFB					

Specimen Receipt Date & Time:	
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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: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
R. B. C /cu.mm	<input type="checkbox"/> Gram-positive	<input type="checkbox"/> Cocci <input type="checkbox"/> Diplococci		AAFB: <input type="checkbox"/> Positive <input type="checkbox"/> No AAFB seen	
Lymphocytes: %	<input type="checkbox"/> Gram Negative	<input type="checkbox"/> Bacilli <input type="checkbox"/> Cocco-bacilli		Glucose:	
Neutrophils %	<input type="checkbox"/> Gram Variable	<input type="checkbox"/> Yeast <input type="checkbox"/> Other.....		Protein:	

Wet Mount:

CULTURE

<input type="checkbox"/> Not done	<input type="checkbox"/> No growth of Microorganism	<input type="checkbox"/> Isolated microorganism (species identification):
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ANTIBIOTIC SUSCEPTIBILITY TESTING

Antibiotic	Zone				Zone						
Amoxillin		R	I	S	Ciprofloxacin		R	I	S	Piperacillin/Tazobactam	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R
Amoxicillin/ Clavulanate		R	I	S	Clindamycin		R	I	S	Tetracycline	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R
Ampicillin		R	I	S	Erythromycin		R	I	S	Trimethoprim/ Sulphamexazole	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R
Ampicillin/Salbactam		R	I	S	Gentamicin		R	I	S	Vancomycin	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R
Ceftazidime		R	I	S	Naladixic acid		R	I	S	Others;	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R
Ceftriaxone/Cefotaxime		R	I	S	Oxacillin		R	I	S		<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> 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:	