

	<b>Patient's details</b> Name: _____ NRIC: _____ Gender: _____ <i>Affix patient's label here</i> Date of birth: _____ Account number: _____ Clinic: _____ Ward: _____ Bed: _____
<b>Laboratory Medicine and Pathology</b>	
<b>MICROBIOLOGY AND MOLECULAR DIAGNOSTICS REQUEST FORM</b>	
<b>Requesting doctor</b> <i>(Please use name stamp if possible)</i>	
Name and MCR number: _____ Phone number: _____ Department: _____ Consultant and MCR number: _____	<i>Laboratory barcode and accession (for laboratory use only)</i>
<b>Clinical information</b>	
	Antibiotic treatment: _____  Recent travel (if yes, specify countries):    Yes / No
<b>Specimen details</b>	<b>Specimen collection date and time</b>  <i>DD/MM/YYYY HH:MM am/pm</i>
<b>Test request(s)</b> <i>(Check box and add details as required)</i>	
<b>Screening tests</b> <input type="checkbox"/> <i>Candida auris</i> <input type="checkbox"/> CPE <input type="checkbox"/> Group B <i>Streptococcus</i> <input type="checkbox"/> MRSA (admission) <input type="checkbox"/> MRSA (transfers in/out) <input type="checkbox"/> MRSA (exit) <input type="checkbox"/> VRE <b>Stool</b> <input type="checkbox"/> <i>C. difficile</i> toxin <input type="checkbox"/> Faecal occult blood <input type="checkbox"/> Ova, cysts & parasites examination <b>Acid-fast bacilli</b> <input type="checkbox"/> Smear: _____ <input type="checkbox"/> Culture: _____ <input type="checkbox"/> Molecular: _____	<b>Microscopy, culture &amp; sensitivities</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Blood culture: _____  <input type="checkbox"/> Body fluids: _____                <input type="checkbox"/> CSF: _____                <input type="checkbox"/> Joint: _____                <input type="checkbox"/> Other: _____  <input type="checkbox"/> Ear: _____  <input type="checkbox"/> Eye: _____  <input type="checkbox"/> Genital: _____                <input type="checkbox"/> Gonococcus: _____                <input type="checkbox"/> IUCD _____                <input type="checkbox"/> Other: _____         </div> <div style="width: 45%;"> <input type="checkbox"/> Lower respiratory:                <input type="checkbox"/> BAL: _____                <input type="checkbox"/> ETA: _____                <input type="checkbox"/> Sputum: _____                <input type="checkbox"/> Other: _____  <input type="checkbox"/> Stool _____  <input type="checkbox"/> Swab: _____  <input type="checkbox"/> Tissue: _____  <input type="checkbox"/> Urine: _____  <input type="checkbox"/> Wound: _____  <input type="checkbox"/> Other: _____         </div> </div>
<b>Molecular testing</b> <input type="checkbox"/> COVID-19 PCR: _____ <input type="checkbox"/> Influenzae A & Influenzae B PCR (qualitative): _____ <input type="checkbox"/> MERS-CoV RNA PCR: _____	<b>Microscopy examination</b> <input type="checkbox"/> Fungal: _____ <input type="checkbox"/> Scabies: _____
	<b>Urine antigen tests</b> <input type="checkbox"/> <i>Legionella</i> <input type="checkbox"/> <i>Streptococcus pneumoniae</i>  <input type="checkbox"/> Respiratory virus multiplex PCR: _____ <input type="checkbox"/> Other: _____
<b>Other test requests</b> <i>(Note: specimens with illegible test requests may be rejected or subject to delayed processing)</i>	
<b>Further information</b> Please refer to the Laboratory Service Guide for information about specific requirements for tests. For enquiries, please call Laboratory Medicine and Pathology on 63611205.	