



CLINICAL BACTERIOLOGY TEST REQUEST FORM

Referring Health facility:
 Patient full name:
 Age Sex:Pt. Card number:
 Specimen ID.....
 Patient address:
 Telephone: Patient

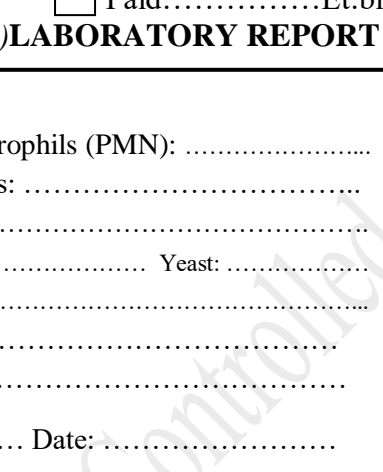
Ordering clinician:
 Phone: clinician..... HF
 Diagnosis:
 Current Antibiotics:
 Clinical History:

Type of Specimen:
 Specimen Collection Date:Time:
 Collected by:
 Date of specimen received: Time:

Test Requested: Routine Urgent
 Gram Stain Routine Culture and DST
 Acid-fast Stain:
 Others:

Cost: Free Paid.....Et.birr
 (For lab use only)

Receipt number
 Reception Specimen ID.



Gram stain:
 Polymorphonuclear neutrophils (PMN):
 Squamous epithelial cells:
 Gram-positive cocci:
 Gram-negative rods: Yeast:
 Others:
India ink:
Acid-fast stain:
 Tech: Date:

Culture (Preliminary report):

 Tech: Date:

Culture (Final report):

 Tech: Date:

Drug	Zone size (mm)	Interp. (S, I, R)	Drug	Zone size (mm)	Interp. (S, I, R)
Ampicillin			Ampicillin		
Cefazolin			Cefazolin		
Gentamicin			Gentamicin		
Amoxicillin/clavulanate			Amoxicillin/clavulanate		
Piperacillin-Tazobactam			Piperacillin-Tazobactam		
Cefuroxime			Cefuroxime		
Cefotaxime			Cefotaxime		
Ciprofloxacin			Ciprofloxacin		
Imipenem			Imipenem		
Trimethoprim/Sulfa			Trimethoprim/Sulfa		
Chloramphenicol			Chloramphenicol		
Nitrofurantoin			Nitrofurantoin		

Final report verified by: Date: