

MICROBIOLOGY - KCHFT (one specimen type per form)

NHS Number*

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* Mandatory fields

Hospital Number* Write details or place PID sticker here

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Family Name (i.e. Surname)*

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Given Name (i.e. Forename)*

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Address*

Post Code*

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Patient Contact Phone Number

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Date of Birth* (DD MM CCYY)

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Female

Male

Date of Collection* (DD/MM/YY)

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Private

NHS

Time of Collection (HH:MM)

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Cancer pathway

Urgent

High Risk

Lab No

Microbiology Use only

* Hospital

M'stone Hosp

TWH

Other Hospital

Consultant Code*

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Ward/GP Surgery/clinic code* (Report sent to)

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GP code

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GP Name

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Extra Copy of Report to

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Collected by* (Print Name)

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Date/Time Received (Microbiology Use ONLY)

Relevant clinical details Other Specimen/site or Tests Required (not listed below)

Antibiotic Therapy: No / Yes (state antibiotics currently on)

Urine MC&S

<input type="checkbox"/> MSU
<input type="checkbox"/> Clean Catch Urine
<input type="checkbox"/> CSU
<input type="checkbox"/> Other Urine (MUST specify type & test)
.....
<input type="checkbox"/> ?UTI <input type="checkbox"/> Pregnant /40

Faeces (MUST state relevant clinical details above)

<input type="checkbox"/> Enteric pathogens (PCR/Culture)
<input type="checkbox"/> GDH/C.difficile (MUST state antibiotic therapy.....)
<input type="checkbox"/> Parasite Microscopy (Foregin Travel.....)
<input type="checkbox"/> Rota/Adenovirus (under 5yr old ONLY)
<input type="checkbox"/> H.pylori antigen
<input type="checkbox"/> Norovirus (Infection Control Request ONLY)

Swab MC&S (Specify clinical details above)

<input type="checkbox"/> Wound swab MUST specify site:	<input type="checkbox"/> Penile Swab
<input type="checkbox"/> Ulcer swab MUST specify site:	<input type="checkbox"/> Throat Swab
<input type="checkbox"/> Skin swab MUST specify site:	
<input type="checkbox"/> Ear swab Specify Right/Left	
<input type="checkbox"/> Eye swab Specifiy Right/Left	
<input type="checkbox"/> Other:.....	
<input type="checkbox"/> Other:.....	

Genital Swab MC&S

<input type="checkbox"/> HVS	<input type="checkbox"/> Discharge
<input type="checkbox"/> CX	<input type="checkbox"/> Pregnant /40
<input type="checkbox"/> Urethral	<input type="checkbox"/> Post partum
<input type="checkbox"/> Other:	

MRSA SCREEN

<input type="checkbox"/> Nose	<input type="checkbox"/> Throat	<input type="checkbox"/> Groin
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	

Respiratory MC&S

<input type="checkbox"/> Sputum
<input type="checkbox"/> Bronchial Washing
<input type="checkbox"/> Other:
<input type="checkbox"/> AAFB (TB) investigation

Other for MC&S

<input type="checkbox"/> Blood Culture
<input type="checkbox"/> Tip of Line:
<input type="checkbox"/> Fluid:
<input type="checkbox"/> Pus:
<input type="checkbox"/> Tissue:

Mycology (Dermatophyte)

<input type="checkbox"/> Skin Scraping:
<input type="checkbox"/> Nail:
<input type="checkbox"/> Hair:
<input type="checkbox"/> AAFB (TB) investigation

Serology

<input type="checkbox"/> HIV 1+2 Ab/Ag	<input type="checkbox"/> Syphilis IgG/M	<input type="checkbox"/> Mycoplasma Ab
<input type="checkbox"/> HBsAg	<input type="checkbox"/> Hepatitis A IgM	<input type="checkbox"/> EBV IgM
<input type="checkbox"/> Hepatitis C Ab	<input type="checkbox"/> anti-HBs	<input type="checkbox"/> Other:

Chlamydia/gonorrhoeae* PCR

<input type="checkbox"/> Vaginal swab	<input type="checkbox"/> 1st catch urine
<input type="checkbox"/> Other:	

* Delete if not required