



UNIVERSITI SAINS MALAYSIA

INSTITUT PERUBATAN DAN PERGIGIAN TERMAJU (IPPT)  
UNIVERSITI SAINS MALAYSIA (USM)

Advanced Diagnostic Laboratory



Institut Perubatan & Pergigian Ter maju

MICROBIOLOGY REQUEST FORM

Name :  Sex : ☐ Male ☐ Female  
R/N :  Age :   
I/C No. :

Date of Admission :  Date & Time of Specimen :   
Ward / Clinic :  Hospital :

**For Laboratory Use Only**

Lab No. :

Section No. :

Date & Time Received :

Received by :

Relevant Clinical History

State if any: a) Current Antibiotic..... b) Prescribed Antibiotic..... Previous similar test : ☐ Yes ☐ No Date:..... Lab. No.:.....

Please tick ☒ below:

**Specimen Source (Must specify):**

- |  |  |   |                                      |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Blood                 | <input type="checkbox"/> Urine-in-out Cath | <input type="checkbox"/> Sputum               | <input type="checkbox"/> Rectal Swab |
| <input type="checkbox"/> Serum / Whole Blood   | <input type="checkbox"/> Urine-suprapubic  | <input type="checkbox"/> Early Morning Sputum |                                      |
| <input type="checkbox"/> CSF                   | <input type="checkbox"/> Eye Discharge     | <input type="checkbox"/> Corneal Scrapping    |                                      |
| <input type="checkbox"/> Stool                 | <input type="checkbox"/> Ear Swab          | <input type="checkbox"/> Wound, Deep          |                                      |
| <input type="checkbox"/> Urine                 | <input type="checkbox"/> Nasal Swab        | <input type="checkbox"/> Wound, Superficial   |                                      |
| <input type="checkbox"/> Urine-Indwelling Cath | <input type="checkbox"/> Throat Swab       | <input type="checkbox"/> Pus Aspirate         |                                      |

☐ Other (describe) \_\_\_\_\_

Special site

**Bacteriology Test**

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Blood C/S  | <input type="checkbox"/> Nasal, Throat C/S |
| <input type="checkbox"/> CSF C/S    | <input type="checkbox"/> Sputum AFB        |
| <input type="checkbox"/> Stool FEME | <input type="checkbox"/> Sputum C/S        |
| <input type="checkbox"/> Stool C/S  |  |
| <input type="checkbox"/> Urine FEME |  |
| <input type="checkbox"/> Urine C/S  |  |
| <input type="checkbox"/> Eye C/S    |  |
| <input type="checkbox"/> Ear C/S    |  |

**Serology Test**

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Dengue   | <input type="checkbox"/> Stool for Rotavirus |
| <input type="checkbox"/> Malaria  | <input type="checkbox"/> Cytomegalovirus     |
| <input type="checkbox"/> VDRL     | <input type="checkbox"/> Mycoplasma          |
| <input type="checkbox"/> HBsAg    |  |
| <input type="checkbox"/> Anti-HBs |  |
| <input type="checkbox"/> HBcAb    |  |
| <input type="checkbox"/> Anti-HCV |  |
| <input type="checkbox"/> HIV      |  |

**Other Tests Requested**

**For Laboratory Use Only**

Name of Doctor : \_\_\_\_\_

Signature & Stamp :

Date : \_\_\_\_\_

## BACTERIOLOGY LABORATORY REPORT

MICROSCOPIC:

REPORT:

COMMENT/S:

Reported by :

Date :

**MICROBIOLOGY REQUEST FORM**

Name :  Sex : ☐ Male ☐ Female  
 R/N :  Age :   
 I/C No. :   
 Date of Admission :  Date & Time of Specimen :   
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For Laboratory Use Only	
Lab No. :	
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**Relevant Clinical History**

State if any: a) Current Antibiotic..... b) Prescribed Antibiotic..... Previous similar test : ☐ Yes ☐ No Date:..... Lab. No.:.....

Please tick ☒ below:

**Specimen Source (Must specify):**

- |  |  |   |                                      |
|--|--|---|--------------------------------------|
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| <input type="checkbox"/> Serum / Whole Blood   | <input type="checkbox"/> Urine-suprapubic  | <input type="checkbox"/> Early Morning Sputum |                                      |
| <input type="checkbox"/> CSF                   | <input type="checkbox"/> Eye Discharge     | <input type="checkbox"/> Corneal Scrapping    |                                      |
| <input type="checkbox"/> Stool                 | <input type="checkbox"/> Ear Swab          | <input type="checkbox"/> Wound, Deep          |                                      |
| <input type="checkbox"/> Urine                 | <input type="checkbox"/> Nasal Swab        | <input type="checkbox"/> Wound, Superficial   |                                      |
| <input type="checkbox"/> Urine-Indwelling Cath | <input type="checkbox"/> Throat Swab       | <input type="checkbox"/> Pus Aspirate         |                                      |

☐ Other (describe) \_\_\_\_\_

Special site

**Bacteriology Test**

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Blood C/S  | <input type="checkbox"/> Nasal, Throat C/S |
| <input type="checkbox"/> CSF C/S    | <input type="checkbox"/> Sputum AFB        |
| <input type="checkbox"/> Stool FEME | <input type="checkbox"/> Sputum C/S        |
| <input type="checkbox"/> Stool C/S  |  |
| <input type="checkbox"/> Urine FEME |  |
| <input type="checkbox"/> Urine C/S  |  |
| <input type="checkbox"/> Eye C/S    |  |
| <input type="checkbox"/> Ear C/S    |  |

**Serology Test**

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Dengue   | <input type="checkbox"/> Stool for Rotavirus |
| <input type="checkbox"/> Malaria  | <input type="checkbox"/> Cytomegalovirus     |
| <input type="checkbox"/> VDRL     | <input type="checkbox"/> Mycoplasma          |
| <input type="checkbox"/> HBsAg    |  |
| <input type="checkbox"/> Anti-HBs |  |
| <input type="checkbox"/> HBcAb    |  |
| <input type="checkbox"/> Anti-HCV |  |
| <input type="checkbox"/> HIV      |  |

**Other Tests Requested**

**For Laboratory Use Only**

Name of Doctor : \_\_\_\_\_

Signature & Stamp :

Date : \_\_\_\_\_

LAB. NO. :

**BACTERIOLOGY LABORATORY ANALYSIS**

**Day 1**

MICROSCOPY :

CULTURE :

Primary sensitivity testing

YES		NO	
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MLT Incharge:

Biochemical test	Organism	1	2	3
Motility				
Catalase				
Coagulase				
Oxidase				
T.S.I.	Slant			
	Butt			
	Gas			
	H <sub>2</sub> S			
Indole				
MR				
Citruse				
Urease				
Colistin				
Novobiocin				
Optocin				

**Day 2**

**Day 3**

API (If needed)

20E	20NE	20NH	20C AUX	20A	20Strep	Coyne

**FINAL RESULT**

Reported by:

Date: