DEPARTMENT OF MICROBIOLOGY, AIIMS RISHIKESH
BACTERIOLOGY TEST REQUISITION FORM

LAB No.

Patient Name:	Age/ Gender:
UHID:	CR No.:
Department:	OPD/IPD/ICU:
Provisional Diagnosis:	Referring Physician:

Brief History:

Had the patient been hospitalized for more than 2 calender days before sampling: Yes/No

Previous relevant reports, if any:

Antibiotic/ Antifungal Therapy with duration (If any):

	Name	Dose/Duration
1.		
2.		
3.		

Test Requested: (Please tick/check te required tests)	◦ Gram Stain ◦ Albert's staining ◦ Culture & Sensitivity — Aerobic ◦ Smear for Bacterial Vaginosis ◦ Hanging Drop for V. cholerae

Type & Site of Specimen: (Tick as applicable)

	Mention Site of Specimen
Aspirate (Specify)	
Blood	Central Line/Peripheral Line (Rt hand/Left Hand)/HD Cath
Biopsy	
Eye	Corneal Button/Corneal Scraping/Conjunctival/Aqueous/Vitreous
Genital and Obstetric Specimens	Endo-cervical aspirate vaginal swab/Urethral discharge/EPS Placenta/RPOC (from NVD/LSCS)
Respiratory sample	BAL/Mini BAL/EBUS/TBNA/Endotracheal Aspirate/Sputum
Sterile Body Fluids (Specify)	CSF/ Ascitic fluid/Pleural fluid/Pericardial/Synovial/Other
Swab	Burn/Ear/Pus/Nasal/Throat/Wound
Stool	
Urine	Mid-Stream/Catheter In-situ/SPC/PCN
Other (Specify)	

FOR LAB USE ONLY

Sample Condition [ ] Good [ ] Leaky [ ] Hemolyzed [ ] Insufficient

Sample Collection (Date/Time):

Sample Receipt (Date/Time):

Sample Sent By:

Sample Received By:

Name & Signature:

Name & Signature: