ADMINISTRATIVE FORM

APP	DOCUMENT NAME	VERSION	DOCUMENT No.
	MICROBIOLOGY TEST REQUEST	4	JRL.7.12.F7

PATIENT INFORMATION (REQUIRED)

HOSPITAL NAME: **King Abdul-Aziz Hospital**
ADDRESS: **Jeddah**

PATIENT'S NAME: (First, Middle, Last) / CODE

AGE | SEX □ M □ F | NATIONAL ID / IQAMA

PATIENT MEDICAL RECORD NUMBER :(MRN#)

DIAGNOSIS:

ANTIMICROBIAL USE :
☐ YES ☐ NO

IF YES MENTION IT :

FOR HOW LONG:

JRL USE ONLY

RECIEVED BY: (name ,signature and stamp)

DATE OF RECEIVE: | TIME OF RECEIVE;
□ A.M. □ P.M.

DEPARTMENT NO.(BARCODE)

SPECIMEN COLLECTION INFORMATION (REQUIRED)

COLLECTED BY(name, signature and stamp)

DATE COLLECTION (DD / MM / YYYY) | TIME COLLECTED (HR: MIN.) □ A.M □ P.M.

REQUESTER INFORMATION (REQUIRED)

REQUESTED BY (physician name ,signature and stamp)

DATE OF REQUEST

SPECIMEN SOURCE (REQUIRED)

□ Bronchial	□ Nasopharyngeal	□Throat swab	□ Other (Please specify)
□ Bone Marrow	□ Rectal	□ Tissue	……
□ CSF	□ Stool	□ Urine	
□ Ear	□ Sputum	□ Wound	
□ Eye			

PLEASE INDICATE TEST(S) REQUESTED

- ☐ Bacterial C/S
- ☐ Yeast ID & AST
- ☐ Stool Examination
- ☐ Occult Blood Test
- ☐ Urea Breath Test
- ☐ H.pylori stool antigen Test
- ☐ Stool Examination Test For Detection of Virus, Bacteria, Parasite by PCR