

# CLINICAL MICROBIOLOGY LABORATORY RAMATHIBODI HOSPITAL

Lab NO.....

H.N. .... Name ..... Age ..... Sex  M  F

COLLECTION TIME

**STAINING:**  Gram  AFB  Other.....

**CULTURE:**  Aerobes  Anaerobes  TB  Fungus  Other.....

DATE	
TIME	
WARD	

**INFECTED:**  in Hospital  on Admission  Don't know Antibiotic Rx: .....

Specimen:	Pus	Swab	Fluid
<input type="checkbox"/> Blood	<input type="checkbox"/> Sinus	<input type="checkbox"/> Throat	<input type="checkbox"/> Sputum
<input type="checkbox"/> Urine	<input type="checkbox"/> Lung	<input type="checkbox"/> Rectal	<input type="checkbox"/> Tracheal aspirate
<input type="checkbox"/> Bone marrow	<input type="checkbox"/> Cutaneous wound	<input type="checkbox"/> Cervical	<input type="checkbox"/> Nasopharyngeal aspirate
<input type="checkbox"/> Lung aspirate	<input type="checkbox"/> Liver	<input type="checkbox"/> Vaginal	<input type="checkbox"/> Bronchial aspirate
<input type="checkbox"/> Tissue from various organs	<input type="checkbox"/> Kidney	<input type="checkbox"/> Placenta	<input type="checkbox"/> Joint
<input type="checkbox"/> Bile	<input type="checkbox"/> Brain	<input type="checkbox"/> Umbilical	<input type="checkbox"/> Pleural
<input type="checkbox"/> CSF	<input type="checkbox"/> Ovary	<input type="checkbox"/> Urethral	<input type="checkbox"/> Pericardial
	<input type="checkbox"/> Spleen	<input type="checkbox"/> Wound	<input type="checkbox"/> Peritoneal dialysate
<input type="checkbox"/> Medical device or Other Specimen (specify site).....	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Ear	<input type="checkbox"/> Ascitic fluid
	<input type="checkbox"/> Appendix	<input type="checkbox"/> Eye	<input type="checkbox"/> Amniotic
Remark .....			

Underlying Disease:
<input type="checkbox"/> Solid tumor
<input type="checkbox"/> Leukemia & lymphoma
<input type="checkbox"/> Hemoglobinopathy
<input type="checkbox"/> COPD
<input type="checkbox"/> Chronic liver disease
<input type="checkbox"/> Valvular heart disease
<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Diabetes mellitus
<input type="checkbox"/> Renal failure
<input type="checkbox"/> Urolithiasis
<input type="checkbox"/> Gall stone
<input type="checkbox"/> SLE
<input type="checkbox"/> Post operation
<input type="checkbox"/> Burn
<input type="checkbox"/> AIDS
<input type="checkbox"/> Transplantation
<input type="checkbox"/> None
<input type="checkbox"/> Unknown
<input type="checkbox"/> Others (specify) .....

Type of infection:			
<input type="checkbox"/> Meningitis	<input type="checkbox"/> Diarrhea & dysentery	<input type="checkbox"/> Inf. of male genital system	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Brain abscess	<input type="checkbox"/> Intra-abdominal	<input type="checkbox"/> Inf. of female genital system	<input type="checkbox"/> Osteomyelitis
<input type="checkbox"/> Other inf. of CNS	<input type="checkbox"/> Acute & subacute endocarditis	<input type="checkbox"/> Abortion	<input type="checkbox"/> Other inf. of bone & joint
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Pericarditis & pyopericardium	<input type="checkbox"/> Complication of pregnancy & child birth	<input type="checkbox"/> Inf. of eye
<input type="checkbox"/> URI	<input type="checkbox"/> Septicemia or bacteremia	<input type="checkbox"/> UTI	<input type="checkbox"/> Inf. of ear
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Other inf. of circul. system	<input type="checkbox"/> Other inf. of urinary tract	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other LRI	<input type="checkbox"/> Fever	<input type="checkbox"/> Soft tissue	<input type="checkbox"/> Other (Specify).....

Request by ..... 10000281