

HOSPITAL NUMBER	271470	CLINICAL DETAILS:	DATE ONSET:	LAB USE ONLY
SURNAME	Builder	FORENAME	Bob	
ADDRESS	Main Street Bobsville Co. Cork			
D.O.B.	01/10/1960	WARD / LOCATION	Room 10	

Insert relevant clinical details

ANTIBIOTIC TREATMENT:
RISK CATEGORY:

BLOOD-BORNE VIRUS
IMMUNOCOMPROMISED

SEX **M** **F** URGENT ROUTINE DATE TAKEN: **27/05/10** TIME: **14.00** CONSULTANT / GP: **Name here**
SIGN: **Signature of staff**

SAMPLE TYPE (PLEASE COMPLETE)

URINE	RESPIRATORY	CATHETER-TIP	BLOOD CULTURE
<input type="checkbox"/> MSU	<input type="checkbox"/> SPUTUM	<input type="checkbox"/> ARTERIAL	<input type="checkbox"/> PERIPHERAL
<input type="checkbox"/> CSU	<input type="checkbox"/> BAL	<input type="checkbox"/> CENTRAL/ VENOUS	<input type="checkbox"/> CENTRAL:
<input type="checkbox"/> CATCH	<input type="checkbox"/> PLEURAL FLUID		<input type="checkbox"/> CSF
<input type="checkbox"/> BAG	<input type="checkbox"/> NPS		
<input type="checkbox"/> EMU	<input type="checkbox"/> ETA	OTHER:	

GENERAL: ANATOMICAL SITE - PLEASE STATE

SWAB: TYPE

HVS

PUS: SITE

FLUID: SITE

TISSUE: SITE

TESTS REQUIRED (PLEASE COMPLETE)

<input type="checkbox"/> MICROSCOPY/ C/S	<input type="checkbox"/> VIRAL CULTURE	<input type="checkbox"/> OCP (give appropriate clinical details)
<input type="checkbox"/> C. DIFFICILE TOXIN	<input type="checkbox"/> RSV	<input type="checkbox"/> NOROVIRUS
<input type="checkbox"/> AFB STAIN / CULTURE	<input type="checkbox"/> FUNGAL CULTURE	<input type="checkbox"/> OCCULT BLOOD

MRSA SCREEN PREVIOUS POSITIVE YES NO

SITES: R. NOSTRIL L. NOSTRIL R. AXILLA L. AXILLA R. GROIN L. GROIN PERINEUM THROAT OTHER

VRE - RECTAL SWAB FOR VRE



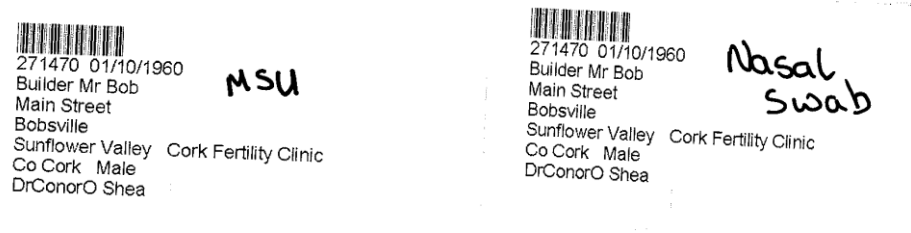
INFORMATION TO BE PROVIDED ON MICROBIOLOGY TEST REQUEST FORMS AND CONTAINERS

Request Form: (Section 4.2 Primary Sample Collection Manual)

The above essential details (highlighted in red) must be documented in a legible manner on the request form (either hand written or a patient label) on all sheets of the request form (front **AND** back).

Blood Transfusion Forms: (refer to section 4.2.1 point 12 + 14, also section 4.3.2 of the primary sample collection manual) person requesting **AND** taking blood need to sign the form. **Reason for test request** should also be on the form (Low Hb, RTHR etc.)

A Genetic Request Consent Form must be filled out for all Chromosomal analysis and Genetic testing test requests, forms available in the Pathology office.



Specimen Container: (Ref Sec 4 subsection 4.3 primary sample collection manual)

Blood sample information, handwritten on bottles, must be initialled by the person taken the specimen.

Anatomical site must be identified on specimen container. (Urine, MSU, Throat, etc.)

24 hour urine containers collected from the Biochemistry laboratory must have start and finish time for the collection recorded on the specimen and form.

Note: all patient samples must be labelled at the bedside to prevent misidentification and labelling errors.

NB. It is important for the correct specimen bottles be used for the correct tests. For more information, including the different request forms and sample bottles required for specific tests, refer to the Primary Sample Collection Manual.

BSC/PATH/GDE/001	Ver. 10.9	Effective Date: 08 / 12 / 11	Att. 4
BON SECOURS HOSPITAL			

