Microbiology Department

Antimicrobial Assay Request Form

Department of Microbiology, Virology and Infection Control
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Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Date and Time receipted into lab

Sender Information

Address:	Contact Number Extension
	Contact Email

Patient Information

Surname		NHS Number
Forename		Sender Hospital Number
DOB (UK Format)	Sex ☐Male ☐ Female	Patient Location/Contact details

Sample Information

Laboratory Reference Number			Sample Type ☐Serum ☐CSF
Date of Collection	Time		
Date and time sent to GOSH			

Requested Test

Please state desired testing Please ensure sample type is suitable for testing – refer to the Microbiology User Manual	☐Amikacin ☐Gentamicin ☐Tobramycin ☐Vancomycin	**Priority status** ☐Routine ☐Urgent

Antimicrobial Agent Information

When was the last dose given:

What was the last dosage given:

Any other details