MICROBIAL ISOLATE REFERRAL FORM

Canterbury Health Laboratories
www.chl.co.nz | 0800THELAB

Samples will not be processed without a completed referral form

THESE **MUST** BE DISCUSSED WITH A CHL MICROBIOLOGIST PRIOR TO DISPATCH		
Gram negative bacillus/cocco-bacillus	Mould with red or brown pigmentation	Potential PC3 pathogen

Referring lab:		**Contact person:**	
Staff member consulted at CHL:			

Patient name:			
NHI:		**DOB:**	
Who do we contact regarding results and on which telephone number?			
Clinical details (with travel history/dates, and antibiotic treatment if applicable):			

Specimen type and site:		
Tests performed and findings thus far:		
Gram:	**Oxidase:**	**Catalase:**
Other tests performed:		

Required testing (circle as appropriate):			
MALDI-TOF	Sequencing	Susceptibilities	Other (state which below)
Any other information or requests:			

CHL use only	
Date and time of specimen arrival:	
Received by:	Discussed with microbiologist? **Y / N**

Issue Date: October 2019