ESR0909
vers2.0 FEB 2021

LABORATORY SERVICES REQUEST FORM
STAPHYLOCOCCUS AUREUS (FROM BLOOD) REFERRAL FORM

INSTRUCTIONS FOR USING THIS FILLABLE FORM:
In Acrobat Reader DC, please complete this form, then 'SAVE AS PDF' to your hard drive. Email your form to NIL@esr.cri.nz and print a copy to accompany your sample. Despatch the form with the isolate to the Nosocomial Infections Laboratory, ESR, Kenepuru Science Centre, 34 Kenepuru Drive, Porirua 5022.

LABORATORY INFORMATION

Submitting laboratory:

Patient DHB:

PATIENT INFORMATION

NHI number:

Surname:

Forenames:

Gender: Date of birth:

Ward: Healthcare facility:

SPECIMEN INFORMATION

Client laboratory number: SNAP study number: (*if enrolled in SNAP*)

Sample site: ☐ Blood: ☐ Other (*please specify*):

Date specimen collected:

SUSCEPTIBILITY RESULTS – Please attach a copy of your susceptibility results or list the susceptibility interpretations below.

Interpretive standard (*tick one*): ☐ EUCAST ☐ CLSI

Interpretation – *please tick applicable*					
Cefoxitin	☐ S	☐ I	☐ R		
Ceftaroline	☐ S	☐ I	☐ R	☐ MIC	mg/L
Ciprofloxacin	☐ S	☐ I	☐ R		
Clindamycin	☐ S	☐ I	☐ R		
Co-trimoxazole	☐ S	☐ I	☐ R		
Daptomycin	☐ S	☐ I	☐ R		
Doxycycline	☐ S	☐ I	☐ R		
Erythromycin	☐ S	☐ I	☐ R		
Fusidic Acid	☐ S	☐ I	☐ R		
Gentamicin	☐ S	☐ I	☐ R		
Linezolid	☐ S	☐ I	☐ R		
Mupirocin	☐ S	☐ I	☐ R		
Oxacillin	☐ S	☐ I	☐ R		
Quinupristin/Dalfopristin	☐ S	☐ I	☐ R		
Rifampicin	☐ S	☐ I	☐ R		
Teicoplanin	☐ S	☐ I	☐ R		
Tetracycline	☐ S	☐ I	☐ R		
Vancomycin	☐ S	☐ I	☐ R	☐ MIC	mg/L

Comments, if required

RESET FORM

Date received at ESR:

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