Microbiology Diagnostic Test Requisition

Patient Information

Patient Name

Date of Birth

Sex Select

Patient ID

Address

Contact Number

Requesting Physician

Physician Name

Contact Number

Department

Clinical Information

Diagnosis / Clinical Details

On Antibiotics? Select

Specimen Information

Specimen Type

Collection Date

Collection Time

Specimen Site

Additional Notes

Test(s) Requested

- [ ] Culture & Sensitivity
- [ ] Gram Stain
- [ ] AFB Smear
- [ ] Other (specify below)

Specify other tests...

Date Requested

Physician Signature