VICTORIAN INFECTIOUS DISEASES REFERENCE LABORATORY (VIDRL) Melbourne Health (APA)

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Mycobacterium Reference Laboratory (MRL) for the state of Victoria
REQUEST FOR EXAMINATION FOR MYCOBACTERIA

Patient Surname:	Given Name:	MRL LAB No.
Address:		
UR Number:	DOB: Sex: M ☐ F ☐	

Senders Ref: Country of Birth:

NATURE OF SPECIMEN (tick ONE box for primary specimen type and ONE box for culture type)

Specimen				**Culture type** (if applicable)	
☐	Sputum	☐	Blood	☐	Solid culture
☐	BAL	☐	CSF	☐	MGIT broth
☐	Bronchial washings	☐	Biopsy/Tissue: _____	☐	MP bottle
☐	Urine	☐	Swab: _____	☐	Bactec mycolytic bottle
☐	Pleural Fluid	☐	Other:		

Collection Date/s: _____

Date Specimen Cultured: _____

Smear result of primary specimen: _____

Test requested:

CLINICAL NOTES:

Requesting practitioners signature: Date:

Requesting practitioners name & address:	ADDRESS FOR REPORT (outside hospitals) Please fill in if different to Dr's address
Phone no: Provider no:	Phone no:

Print Form **Reset Form**

THIS FORM NOT TO BE USED FOR HIC/MEDICARE BILLING