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|  | **REQUEST FORM****Candida auris isolate REFERRAL** |  |
| VIDRL Medipath No.(VIDRL Use only) | Victorian Infectious Disease Reference LaboratoryMelbourne Health (APA)Peter Doherty Institute for Infection and Immunity, 792 Elizabeth Street, Melbourne, VIC 3000t: (03) 9342 9600 f: (03) 9342 9606 e: vidrl@vidrl.org.au w: www.vidrl.org.au |  |
| Sender information

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| Laboratory: ……………………………………………………….……………………………………………………………….………………………………………………………………………………………………………………………………………………………………………………..………Address: ………………………………………………………………….……………………………………………………………….…………………………………………………………………………………………………………………………………………………………………………..………………………………………………………………….……………………………………………………………….…………………………………………………………………………………………………………………………… Postcode: ……………………………………………………Phone no: …………………………………………………………………………………………….…………………………………………………..…… Fax no: ……………………………………………………………………………………………………….……………………………Requesting doctor: ……………………………………………………………………………………………………………………………… Requesting doctor phone no: …………………………………………………………………………………**Copy to:** Name: ………………………………………………………………………………………………………………………………….... Fax no: ……………………………………………………………………………………………………………………………………. |

Patient details

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| Surname: ……………………….………………………………………………………… Given Name(s): .………………………………………………………………………………… Sex: M 🞏 F 🞏 Not known 🞏Date of birth: ………………………………………………..………………………… Postcode: ……………………………........ Patient identifier (UR no.): ………..………………………………………………………………..…………Patient phone no: …………………….…………………………………………………………….……………………………….……… |

**Patient risk factors (Laboratory Use Only)**

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| At the time of sample collection, patient was in a:Health care facility 🞏 Aged care facility 🞏 GP/Medical clinic 🞏 Other 🞏 Not known 🞏Facility name: …………..……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………....Ward or unit: …………..…………..………………………………………………………………………………………………………………….. Date of admission: ………………………….……………………..………………………………………………………...Reason for sampling: Clinically indicated 🞏 Screening 🞏 Not known 🞏Has patient been in an overseas health care facility in the past 12 months? Yes 🞏 No 🞏 Not known 🞏If yes, which country: …………………………………………………………………………………………….. |

Isolate and sample details

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| Organism name (species): …..…………………………………………………………………………………..…..……..……..……. Submitting laboratory number: ….…………………………………………………………………..………...Isolated from (sample type/site): ……………………………………………………………………………….………………….….… Date of sample collection: ……………………………………………………………………………Test Requested: ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….. |

Submitting laboratory testing results (Laboratory Use Only)

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| **Tick all that apply:**🞏 Confirmed via MALDI-TOF🞏 Confirmed via other method: …………………………………………………………………………………………………………………………………………………………………………………………………..**Antifungal sensitivity testing:**Performed? Yes 🞏 No 🞏Results:Amphotericin B: …………… mg/LFluconazole: …………… mg/LVoriconazole: …………… mg/LCaspofungin: …………… mg/LMicafungin: …………… mg/LAnidulafungin: …………… mg/L**Please send a printout of your antimicrobial results with this form** |

**Submitted by**

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| Name: ……………..………………………………………………………………………..…………..………………..…………..…… Signed: ……………………………………………………………..…………………… Date: ………………………………….………………… |

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