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|  | **REQUEST FORM**  **Candida auris isolate REFERRAL** | | |  |
| VIDRL Medipath No.  (VIDRL Use only) | | Victorian Infectious Disease Reference Laboratory Melbourne 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](mailto:vidrl@vidrl.org.au) w: www.vidrl.org.au |  | |
| Sender information   |  | | --- | | Laboratory: ……………………………………………………….……………………………………………………………….………………………………………………………………………………………………………………………………………………………………………………..………  Address: ………………………………………………………………….……………………………………………………………….…………………………………………………………………………………………………………………………………………………………………………..………  ………………………………………………………….……………………………………………………………….…………………………………………………………………………………………………………………………… Postcode: ……………………………………………………  Phone no: …………………………………………………………………………………………….…………………………………………………..…… Fax no: ……………………………………………………………………………………………………….……………………………  Requesting doctor: ……………………………………………………………………………………………………………………………… Requesting doctor phone no: …………………………………………………………………………………  **Copy to:** Name: ………………………………………………………………………………………………………………………………….... Fax no: ……………………………………………………………………………………………………………………………………. |   Patient details   |  | | --- | | 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)**   |  | | --- | | 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   |  | | --- | | Organism name (species): …..…………………………………………………………………………………..…..……..……..……. Submitting laboratory number: ….…………………………………………………………………..………...  Isolated from (sample type/site): ……………………………………………………………………………….………………….….… Date of sample collection: ……………………………………………………………………………  Test Requested: ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….. |   Submitting laboratory testing results (Laboratory Use Only)   |  | | --- | | **Tick all that apply:**  🞏 Confirmed via MALDI-TOF  🞏 Confirmed via other method: …………………………………………………………………………………………………………………………………………………………………………………………………..  **Antifungal sensitivity testing:**  Performed? Yes 🞏 No 🞏  Results:  Amphotericin B: …………… mg/L  Fluconazole: …………… mg/L  Voriconazole: …………… mg/L  Caspofungin: …………… mg/L  Micafungin: …………… mg/L  Anidulafungin: …………… mg/L  **Please send a printout of your antimicrobial results with this form** |   **Submitted by**   |  | | --- | | Name: ……………..………………………………………………………………………..…………..………………..…………..…… Signed: ……………………………………………………………..…………………… Date: ………………………………….………………… | | | | | |