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IMR/IDRC/BACT/MYCO/01

MYCOLOGY REQUEST FORM

1. DEMOGRAPHY

Name:		**R/N:**
I/C No.:		**Ward/Clinic/Laboratory:**
Age:		**Hospital:**
Gender: ☐ M ☐ F	**Race**: ☐ Malay ☐ Chinese ☐ Indian ☐ Others:	**Specimen source:**
2. CLINICAL HISTORY & EXAMINATION FINDINGS:		

Diagnosis:	**Duration of illness :**

Underlying illness: : ☐ DM ☐ ESRF on dialysis ☐ Cancer , site :..... ☐ Chemotherapy ☐ HIV (CD4:.... , CD8: .....) ☐ Thalassemia transfusion dependant ☐ Hematological malignancy ☐ Organ transplant ☐ Bone marrow transplant ☐ Autoimmune disease ☐ Neutropenia ☐ Others:..... ☐ History of trauma/injury, site : ..... ☐ Chronic corticosteroid use ☐ Tuberculosis ☐ Prolonged hospital stay

Symptoms and Signs:	☐ Eye lesion/ corneal ulcer	☐ Cough	☐ Shortness of breath	☐ Lymphadenopathy
	☐ Blurring of vision	☐ Headache	☐ Bone lesions/pain, site:.....	☐ Loss of weight
	☐ Skin lesions, site :.....	☐ Seizures	☐ Joint lesions/pain. site:.....	☐ Loss of appetite
	☐ Onychomycosis	☐ Neck stiffness	☐ Fatigue and weakness	☐ Sepsis
	☐ Fever	☐ Hypotension	☐ Gastrointestinal symptoms, specify :.....	
	☐ Chills/rigors	☐ Hypertension	☐ Others :.....	

3. HIGH RISK SOCIAL HISTORY

Occupation/hobby:

☐ **Smoking** ☐ **Obesity** ☐ **Alcohol Abuse** ☐ **Drug Abuse**
☐ **Others:** .....

Contact with animals: ☐ Cat ☐ Dog ☐ Horse ☐ Cow ☐ Goat ☐ Bird ☐ Pig ☐ Rodents ☐ Reptiles ☐ Others: .....

4. HISTORY OF INVESTIGATIONS

☐ Full Blood Count at presentation: Hb: ....., Platelet: ....., TWC: ....., ANC: ....., Neutrophil %: ....., Lymphocytes %: .....

☐ Culture and identification of specimen:

☐ HPE of specimen:

☐ Others investigations:

Imaging Findings: ☐ X-ray ☐ Ultrasound ☐ CT ☐ MRI

5. HISTORY OF TREATMENT (IF ANY)

☐ Fluconazole, duration: ....., Date initiated:	☐ Deoxycholate Amphotericin B, duration: ....., Date initiated: .....
☐ Ketoconazole, duration: ....., Date initiated:	☐ Lipid-formulation Amphotericin B, duration: ....., Date initiated: .....
☐ Itraconazole, duration: ....., Date initiated:	☐ Terbinafine, duration: ....., Date initiated: .....
☐ Caspofungin, duration: ....., Date initiated:	☐ Flucytosine, duration: ....., Date initiated: .....
☐ Micafungin, duration: ....., Date initiated:	☐ Other Antifungals, duration: ....., Date initiated: .....

6.TEST REQUIRED (PLEASE TICK)	☐ Fungal culture *(for fresh clinical specimens only)*
	☐ Fungal identification *(for pure clinical fungal isolate only)*
	☐ Fungal PCR *(for fresh clinical specimens only)*
	☐ Anti-fungal susceptibility testing *(for pure clinical yeast isolate only)* *-To provide identification test report if done*
	☐ Anti-fungal susceptibility testing *for mold* (Research)
7. SPECIMEN COLLECTION DATE	Date: Time:

8. APPLICANT

Date: .....

.....
Signature and stamp