

ICMR-Advanced Mycology Diagnostic and Research Centre, NIMS

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Clinical Mycology test request form

ICMR-AMDRC LAB Accession No:

Patient Name:

Age:

M/F

Hospital ID:

Senders Details:

Name*

Email Id*

Address*

Contact No*

Specimen details:

Specimen Type and Site:

(e.g sputum, Pus from brain abscess etc.)

Date of collection:

[Please state if the sample requires handling at containment level 3. If so, please contact the Laboratory prior to sending]

Clinical details

[Presenting complaints, Past History, Family history, Travel History]

Provisional diagnosis:

Immunocompromised? Yes/ No (If Yes, specify):

Treatment History: (Previous history of antibiotics and antifungals used, specify name of drug and duration)

TESTS REQUESTED: [LINK TO MYCOLOGY TESTS](#)

Test Name & Code: _____

Date : _____

Signature of the referring Doctor