Leptospirosis Laboratory Request Form
Bacteriology Unit,
Institute for Medical Research
Jalan Pahang, 50588 Kuala Lumpur **Tel: 03-26162582**

A. SENDER'S INFORMATION

Hospital: _____ _____

Ward: _____

Date of Admission: ___/___/___

Name of Requesting Doctor: _____

Signature: _____

Tel No: _____

Fax No: _____

B. PATIENT INFORMATION

Name: _____

Address: _____

_____

IC No: _____

R/N No: _____

Age: _____ Date of Birth: ___/___/___

Race: ☐ Malay ☐ Chinese ☐ Indian

☐ Others: _____

Sex: ☐ Male ☐ Female

Occupation: _____

C. CLINICAL FEATURES / COMPLICATIONS

Diagnosis date: ___/___/___

Illness duration: _____days

Sign & Symptoms:

☐ Fever, duration: _____
☐ Chills & rigors
☐ Anorexia
☐ Headache
☐ Retroorbital pain
☐ Calf pain
☐ Arthralgia
☐ Myalgia
☐ Conjunctival redness
☐ Abdominal pain
☐ Cough
☐ Hemoptysis
☐ Nausea/vomitting
☐ Jaundice
☐ Diarrhoea
☐ Rash
☐ Convulsion
☐ Hepatomegaly
☐ Lymphadenopathy
☐ Others: _____

Antibiotic therapy: _____
Date started : _____

D. EXPOSURE

☐ Bathing/swimming(where)_____
☐ Hunting(where)_____
☐ Fishing(where)_____
☐ Camping(where)_____
☐ Contact with animals (cattle,cow,rodents)

E. SPECIMEN INFORMATION

Date of collection: ___/___/____

Type of specimen:

☐ Blood for PCR (2-3 mls in EDTA tube, only for cases with fever lesser than 10 days, prior to antibiotics)

☐ Serum for MAT (send only if Leptospirosis rapid test is positive or equivocal)

☐ Culture(2-3 mls blood in Heparin tubes; for cases prior to antibiotics only)

(For MAT please send second serum samples 2 weeks after first sample)

F. LABORATORY INFORMATION

Date specimen received: ___/___/____

Date test performed: ___/___/____

Result of test:

Verified by: _____