**Notifier details**

**Patient details**

**Specimen and testing details**

**Antimicrobial susceptibility testing results**

**(Laboratory staff)**

Name and Surname:



Designation:



Hospital/Clinic:



Address:



Province: **Choose an item.**

Tel:



Cell:



Email:



Alternative contact details:



Patient name:



Date of birth:



Age:



Sex:





Hospital number:



Referring laboratory:



Specimen type:



Date specimen collected:

**Click or tap to enter a date.**

Specimen laboratory number:



Assays/tests used for ID confirmation

(please list all):



Assay/test used for AST:

**Choose an item.**

**EUCAST MIC by E-test (µg/ml)**

Antibiotic / Breakpoint

**Choose an item. Choose an item.**

**Choose an item. Choose an item.**

**Choose an item. Choose an item.**

**Disc diffusion (mm)**

Antibiotic / Zone diameter (mm)

**Choose an item.** 

**Choose an item.** 

**Choose an item.** 