**Instructions:**For all infants who are enrolled in SIP, microbiology test. This form should be completed to record details of the microbiology tests conducted.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Was specimen collected for microbiology test? | 1Yes | 2No | 3Don’t know |  | | |
| 2. If yes, were tests completed? | 1Yes | 2No | 3Don’t know |  | | |
| Microbiology Findings  Date of test ((DD – MM – YYYY) | **Record results for all tests done** | | |  | | |
| 3.0 |\_\_|\_\_|-|\_\_|\_\_|-|\_\_|\_\_|\_\_|\_\_| | First test | | | Remarks | | |
| 3.1 What specimen was cultured? Tick all that apply? | blood  CSF  Pus from umbilicus  Pus from eye discharge  Pus from skin  Other: SPECIFY  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | | |
| 3.2 What specimen was cultured and positive? Tick all that apply? | blood  CSF  Pus from umbilicus  Pus from eye discharge  Pus from skin, abscess etc  Other: SPECIFY  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | | |
| 3.3 What organisms were detected? Tick all that apply. | E. coli  Group B streptococcus  Klebsiella pneumoniae  Acinetobacter  Psudomonas  Staph aureus  Coagulase negative staph- Staph epidermidis  Listeria monocytogenes  Enterobacter  Serratia  Candida albicans  *no growth*  Other: SPECIFY  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | | |
| 3.4 If an organism is detected, what was the susceptibility pattern to?  Gentamycin  Kanamycin  Penicillin G  Ampicillin  Cloxacillin  Cephtazdime  Vancomycin  Amikacin  Agumentin  Cephalothin  chloramphenicol  *E*rythromycin  Methicillin  Nalldixic Acid  Nitrofurantoin  Amoxil  cefotaxime  Sulfadiazine  Tetracycline  Trimethoprim Sulfamethoxazole  Ceftriaxone  Doxycyclin  Norfloxacine  carbencillin  Streptomycin  Peivmyxin  Other: SPECIFY  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | *Susceptible intermediate resistant* | | |  | | |
| 4. Were tests sent for QC? | 1Yes | 2No | 3Don’t know |  |  |  | |
| 4.1 If yes, record results |  |  |  |  |  |  | |
| **FORM COMPLETION** |  |  |  |  |  |  | |
| 5. Tests completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name) 6. Date form completed: |\_\_|\_\_|-|\_\_|\_\_|-|\_\_|\_\_|\_\_|\_\_| (DD – MM – YYYY) | | | | | | |