

To be completed for any prescription of bacteriological examination

Patient identification (Name, Surname, DOB) :	
Laboratory / Hospital :	Service :
Reason of hospitalize :	
Medical history :	
Taking antibiotics during previous 6 weeks YES <input type="checkbox"/> NO <input type="checkbox"/>	If yes Antibiotic name :
Residence (city) :	Traveling abroad : (when, where)

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