

Bacteria Culture Test Form

Patient Information

Patient Name:

Date of Birth:

Medical Record Number:

Contact Information:

Sample Collection

Type of Sample: (e.g., Blood, Urine, Swab)

Date and Time of Collection:

Special Instructions for Collection:

Culture Medium Inoculation

Culture Medium Used:

Date and Time of Inoculation:

Incubation Conditions

Incubation Temperature:

Incubation Duration:

Microscopic Examination and Biochemical Tests

Microscopic Findings:

Biochemical Test Results:

Antibiotic Sensitivity Testing

- Antibiotics Tested:
- Susceptibility/Resistance Results:

Comments/Notes

Healthcare Provider's Name:

Signature:

Date: