



Specialist Antimicrobial Chemotherapy Unit (SACU)

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SACU REQUEST FORM

SENDER'S INFORMATION

Name, Address and Telephone Number:

Name of BMS referring the isolate:

PATIENT and SAMPLE DETAILS

Surname: _____

Forename: _____

Date of Birth: _____

Gender: M F Unknown

NHS Number: _____

Episode Number: _____

Sample Number: _____

Collection date: _____

Date sent to SACU: _____

PACKING SLIP (issued using "MOTH" code)

Number: _____ NOT Applicable (e.g. Sender not in Wales)

ISOLATE IDENTIFICATION

Is this isolate a suspected Hazard Group 3 microorganism? YES NO

ISOLATED FROM

- Blood Sputum Screen
 Tissue Urine Wound
 Other (please state below):

INVESTIGATION REQUIRED

- vanA/B detection in *Enterococcus* spp.
 mecA/C detection in *Staphylococcus* spp.
 PVL detection in *S. aureus* complex
 Carbapenem resistance
 3rd Generation Cephalosporin resistance
 Resistance Alert
 Antimicrobial Susceptibility Testing
 (please state antimicrobials required below)
 Confirmation of local results
 (please state below)
 Other (please state below)

Additional Information and/or Investigation Required