

## Anaerobic bacteria including *Actinomyces* Submission of isolates for identification and susceptibility testing

UK Anaerobe Reference Unit, Public Health Wales,  
University Hospital of Wales, Cardiff, CF14 4XW  
Phone: +44(0)2921842171  
DX: 6070100 CARDIFF 90 CF  
[www.publichealthwales.org/anaerobe-reference-unit](http://www.publichealthwales.org/anaerobe-reference-unit)



**\*Completion of all fields will allow more timely and clinically relevant reporting\***

### SENDER INFORMATION

Name and address Contact phone no.  
Email contact for urgent or unusual results

PO number (if applicable)  
Report to be sent FAO:

### PATIENT /SOURCE INFORMATION

Human  Animal  Environment  Food  Other (please specify)

Inpatient  Outpatient  GP patient  Donor  High risk  IVDU  Other (please specify)

Surname: Forename:

NHS number: CRN/Hospital number:

Date of birth: Age:

Gender:  Male  Female  Unknown Risk factors:

### CLINICAL DETAILS & ANTIMICROBIAL HISTORY

<input type="checkbox"/> Bacteraemia	<input type="checkbox"/> Endocarditis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Prosthetic joint replacement
<input type="checkbox"/> Bite (animal)	<input type="checkbox"/> Erythema/rash	<input type="checkbox"/> Post-mortem	<input type="checkbox"/> Pyrexia/fever
<input type="checkbox"/> Bite (human)	<input type="checkbox"/> Lemierre's	<input type="checkbox"/> Postpartum	<input type="checkbox"/> Sepsis
<input type="checkbox"/> Cancer/tumour	<input type="checkbox"/> Necrotizing fasciitis	<input type="checkbox"/> Post-surgery	<input type="checkbox"/> Immunocompromised
<input type="checkbox"/> Chest infection	<input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> Post-transplant	<input type="checkbox"/> Other (please specify):

Antimicrobial therapy:

### SPECIMEN DETAILS

Sender's reference number: Episode No (Welsh labs only):

Isolation site:  
 blood  wound\*  abscess\*  throat  genital  IUCD  bone\*  CSF  sterile fluid\*  prosthesis\*  pus\*  
 tissue\*  urine  faeces  sputum  environment  other\*  
 \*Please specify site:

Are HG3 organisms suspected: Yes  No.  Please provide an auramine phenol/ZN result if AFB could be present

Collection date: Date sent to ARU:

Presumptive ID:

Method of identification:  MALDI-TOF & score \_\_\_\_\_  Vitek  API  Rapid ANA  MAST ring

Gram stain & result:  positive  negative  variable  cocci  bacilli  coccobacilli

Other (please specify)\*

Metronidazole:  zone  no zone  reduced zone Growth:  ANO<sub>2</sub>  O<sub>2</sub>  CO<sub>2</sub>  slow growing

### REASON FOR REFERRAL

unable to identify  confirmation of results  AST & therapeutic guidance (see below)  
 unusual resistance\*  increased number  other\*  
 \*Please specify:

### GENERIC AST PANEL:

ceftriaxone  clindamycin  co-amoxiclav  meropenem  metronidazole  penicillin  piperacillin/tazobactam  vancomycin

- Additional AST may be performed based on completion of full clinical details and routine panel results (see website)
- If additional AST of non-routine agents is clinically indicated, please contact the UKARU **prior** to sending the isolate to prevent delays in testing and reporting.

### For ARU use only:

sw  cm  sl  pl  other Ref number: Date rec: