**Date & Time taken:**

Sample 1:

Sample 2:

Sample 3:

Sample 4:

Sample 5:

Other:



Test Request:

1st Stage:

2nd Stage:

Direct Exchange:  
If Yes, please state for infection or aseptic loosening

Implant Retained:  
If Yes, please state time from original surgery

Recent or Current Antibiotics:  
If Yes, please specify

Additional Clinical Information:

Clinical Information

Patient Details

Hospital Information

Name:

Date of Birth:

Hospital Number:

Sex:

Email:

Telephone:

Fax:

Hospital:

Ward:

Consultant:

Address:

Samples