



Mycology

St John's Institute Of Dermatology St Thomas' Hospital Westminster Bridge Road London SE1 7EH Tel: 020 7188 6400 Fax:020 7188 6258

Mycology Request Lab. Ref. No: Sent by: Patient: Signature. Surname: Forename: Print Name. Date of Birth: Return address: Hospital Number: Guys St T Previous Mycology Number: Date: Provisional Diagnosis and Relevant History: Sites to be Examined: (Please be specific.) Date Specimen Taken: **DIRECT EXAMINATION:**

Date:

Signature:





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CULTURE RESULT:

Date:

Signature:

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