بسم الله الرحمن الرحيم

STATE OF KUWAIT
MINISTRY OF HEALTH
AS'AD AL-HAMAD
DERMATOLOGY CENTER
AL-SABAH HOSPITAL

دولة الكويت
وزارة الصحة
مركز أسعد الحمد للأمراض الجلدية
مستشفى الصباح

LABORATORY EXAMINATION REQUEST FORM

MYCOLOGY

Name of Patient: ..... .
Age: ..... **yrs. Sex:** ..... **. Nationality:** ..... .
Residence: ..... .
Nature of Specimen: ..... .
Examination Required: ..... .
Short History: .....
.....
..... .
.....
Clinical Diagnosis: ..... .
Referring Center: ..... .
Referring Doctor:..... **Date**: ..... /..... /..... .
Doctor's Stamp and Signature: ..... .

LAB. USE ONLY	RESULTS	LAB. NO.:

Direct Microscopy: ..... .
..... .

Culture Examination: ..... .
..... .

Comments: ..... .
..... .
..... .
..... .
..... .
..... .
..... .
..... .
..... .
..... .

Signature: ..... **Date**: ..... /..... /.....