

CMPT
Mycology Susceptibility Testing Report Form

Laboratory Name:	Laboratory Number:
Signature:	Specimen Number:

Mycology Identification:

Additional Comments (check all that apply)

this laboratory does not perform susceptibility tests

this isolate would be referred out for susceptibility testing

this isolate would be referred for additional susceptibility testing

Please indicate the Antimicrobial Susceptibility Testing Method or system used for each isolate

<input type="checkbox"/> Disk Diffusion	<input type="checkbox"/> E-test	<input type="checkbox"/> Microbroth dilution	<input type="checkbox"/> Macrobroth dilution
<input type="checkbox"/> Fungitest®	<input type="checkbox"/> Sensititre® YeastOne™	<input type="checkbox"/> Other, please specify:	

For each antimicrobial tested, please provide actual and reported results, MIC (mg/L) or zone size (mm)

Antimicrobial Agent	Actual S/I/R	Reported S/I/R	MIC/Zone	Antimicrobial Agent	Actual S/I/R	Reported S/I/R	MIC/Zone
Amphotericin B				Voriconazole			
Fluconazole				5-Fluorocytosine			
Itraconazole				Posaconazole			
Ravuconazole				Ketoconazole			
Anidulafungin				Micafungin			
Caspofungin							