MPH12-25

Republic of Lebanon
Ministry of Public Health

الجمهورية اللبنانية
وزارة الصحة العامة

Application for Special Antimicrobial Agents

رقم المعاملة

❖ Patient Information

رقم الهوية : ..... رقم بطاقة الكرنتينا : .....

اسم المريض : ..... اسم الأب: ..... الشهرة: .....

اسم الأم: ..... تاريخ الولادة: ...../...../..... ذكر ☐ انثى ☐

العنوان: .....

المحافظة والقضاء : ..... البلدة : ..... الشارع : ..... ملك : ..... هاتف : ...../.....

❖ Medical Information

Height: .....cm **Weight**: .....kg **BP**: ...../.....mmHg Date of diagnosis: ...../...../.....

Previous Antibiotherapy: Yes ☐ No ☐ If yes, specify: .....

Underlying condition:.....

❖ Type of infection:

Diagnosis:.....

1. If bacterial species: culture result:
   - Sample: ..... Date: ..... /...../.....
   - Organism: ..... Date: ..... /...../.....
   - Antibiotic susceptibilities: ..... Date: ..... /...../.....
2. If fungal species:
   - Culture: ..... Date: ..... /...../.....
   - Or pathology: ..... Date: ..... /...../.....
   - Or Radiology: ..... Date: ..... /...../.....
3. If Viral species:
   - Serology: ..... Date: ..... /...../.....
   - Or PCR: ..... Date: ..... /...../.....
   - Or pathology: ..... Date: ..... /...../.....

❖ Requested Antimicrobial:

Medication	Unit dose	Mode of administration	Duration of treatment

Side effect of treatment: Allergy Yes ☐ No ☐ If yes, to what: .....

❖ Physician Information

Physician Name: ..... Specialty: .....

Telephone: ...../..... Order of Physicians Number:.....

Date: .... / .... / ..... Signature & Stamp:

❖ Documents to be submitted:

1. صورة عن بطاقة الكرنتينا او اخراج القيد
2. Copy of laboratory or X-Ray results as requested in the application

N.B:

1. This form must be completed by the doctor
2. All information should be attached
3. All attached reports and studies should be original and official
4. All fields are mandatory