# MRSA Test Request Form

*Patient Information*

- **Patient Name:** John Smith
- **Date of Birth:** 03/15/1980
- **Medical Record Number:** 123456

*Clinical Information*

- **Reason for MRSA Testing:** Pre-surgery screening
- **Clinical Symptoms:** None
- **Antibiotic History:** None
- **Allergies:** No known allergies

*Sample Collection*

- **Site for Sample Collection:** Nasal swab
- **Date and Time of Sample Collection:** 10/20/2023, 09:30 AM
- **Collector's Name and Signature:** Dr. Jane Doe, MD

*Laboratory Instructions*

- **Preferred Test Method:** PCR
- **Urgency:** Routine
- **Additional Comments:** None

***Patient Consent***

I, the undersigned patient, consent to the MRSA test described above. I understand the purpose of this test and its potential implications.

**Patient's Signature:** John Smith **Date:** 10/20/2023