

# Yeast Infection Test Report

## Patient Details

- Full Name: \_\_\_\_\_
- Patient ID: \_\_\_\_\_
- Age: \_\_\_\_\_ Gender: \_\_\_\_\_
- Date of Birth: \_\_\_\_\_
- Contact Information:
  - Phone: \_\_\_\_\_
  - Email: \_\_\_\_\_
  - Address: \_\_\_\_\_

## Clinical Details

- Referring Physician: \_\_\_\_\_
- Date of Sample Collection: \_\_\_\_\_
- Type of Sample: (e.g., vaginal swab, oral swab, etc.)
- Clinical Symptoms:
  - Itching: \_\_\_\_\_ (Yes/No)
  - Burning: \_\_\_\_\_ (Yes/No)
  - Discharge (describe): \_\_\_\_\_
  - Redness: \_\_\_\_\_ (Yes/No)
  - Swelling: \_\_\_\_\_ (Yes/No)
  - Pain: \_\_\_\_\_ (Yes/No)
  - Other: \_\_\_\_\_

## Microscopic Examination

### 1. Wet Mount Preparation:

- Presence of budding yeast cells: \_\_\_\_\_ (Yes/No)
- Presence of pseudohyphae: \_\_\_\_\_ (Yes/No)
- White blood cells count: \_\_\_\_\_ per high power field
- Comments: \_\_\_\_\_

### 2. Gram Stain:

- Gram-positive budding yeast cells: \_\_\_\_\_ (Yes/No)
- Gram-positive pseudohyphae: \_\_\_\_\_ (Yes/No)
- Comments: \_\_\_\_\_

## Culture Examination

1. **Medium Used:** \_\_\_\_\_ (e.g., Sabouraud Dextrose Agar)

2. **Incubation Period:** \_\_\_\_\_ days at \_\_\_\_\_ °C

### 3. Observations

- Colony morphology: \_\_\_\_\_
- Size of the colony: \_\_\_\_\_ mm
- Texture: \_\_\_\_\_
- Color of the colony: \_\_\_\_\_
- Hemolysis (if any): \_\_\_\_\_
- Other notable features: \_\_\_\_\_

## Biochemical and Molecular Tests (if performed)

1. **Germ Tube Test:** \_\_\_\_\_ (Positive/Negative)

- Comments: \_\_\_\_\_

### 2. CHROMagar Candida

- Color differentiation: \_\_\_\_\_
- Comments: \_\_\_\_\_

### 3. Molecular Identification (e.g., PCR)

- Target gene/sequence: \_\_\_\_\_
- Result: \_\_\_\_\_ (Positive/Negative)
- Comments: \_\_\_\_\_

## Final Identification

- **Species of Candida Identified:** \_\_\_\_\_

## Antifungal Susceptibility Testing (if performed)

Antifungal Agent	MIC ( $\mu\text{g/mL}$ )	Interpretation (S/I/R)
Fluconazole		
Amphotericin B		
Itraconazole		
[Other]		

## Recommendations

- Preferred antifungal treatment: \_\_\_\_\_
- Duration of treatment: \_\_\_\_\_ days/weeks
- Follow-up required: \_\_\_\_\_ (Yes/No)
- Additional notes or precautions: \_\_\_\_\_

## Laboratory Details

- Name of the Lab: \_\_\_\_\_
- Address: \_\_\_\_\_
- Contact Information:
  - Phone: \_\_\_\_\_
  - Email: \_\_\_\_\_
- Lab Technician: \_\_\_\_\_
- Lab Director/Pathologist: \_\_\_\_\_
- Date of Report: \_\_\_\_\_

This template provides a comprehensive overview of the tests and results. However, it's essential to remember that the specific tests, methodologies, and interpretations can vary based on the laboratory and the available resources. Always consult with a healthcare professional or laboratory technician for specific details and interpretations.