



## Guidelines for completing Referral Forms

A list of all tests and services offered by specialist and reference microbiology laboratories can be found at:

<https://www.gov.uk/specialist-and-reference-microbiology-laboratory-tests-and-services>

The page carries a link to the appropriate referral form to use and to the relevant laboratory user manual for more information.

Failure to use the correct request form or to provide relevant information may mean that the laboratory is not able to process your request in the most efficient way which may prevent us from meeting published turnaround times.

**Referral form title and index number**  
The title of the form should indicate which tests/services it should be used for and each form also has an Index number for each reference

**Our laboratory contact details**

Address (both Royal Mail and DX) and other contact details of the laboratory to which samples and completed request forms should be sent.

**†† Your purchase order or billing reference**

This will appear on your invoice

**PHE investigation**

Quoting our reference number back will help us associate the new requests for testing with any previously submitted.

**† Patient/source details**

Use this section to provide as much information about the patient or source as possible. This helps us to link samples from the same patient so that relevant results are considered together.

**!! The information requested in this section helps us ensure that specimens received are handled with appropriate containment for the risk posed.**

**Your results**

Provision of these data may help us tailor the service and speed up turnaround times

**Clinical information**

The information requested in this section is often specific to the test/service and helps us ensure results are interpreted correctly

**† Your address**

We will use this address (particularly the postcode) to find you in our system. **Please ensure you are consistent with the address you provide.** Please provide a contact name where possible

**†† Your sample reference number**

This will appear on your report and invoice

**Details about the sample(s) submitted**

If more than one sample is required for the service, this will be clearly marked. Please provide as much detail as possible

**‡ Indicate tests to be performed.**

If the form has a list of tests but NOT the one you want, please confirm you have the correct form.

**Further information**

Please use the other comments box to expand on information provided above or to provide any information not specifically requested you think may be important

**B2**

**Public Health England**

**Neisseria gonorrhoeae Isolate Referral**

Bacteria Reference Laboratory (STBRU)  
61 Colindale Avenue  
London NW9 5HT

Phone: +44 (0)20 8327 7887  
STBRU@phe.gov.uk  
www.gov.uk/phe

PHE Colindale  
Bacteriology  
DX 6530002  
Colindale NW

Please write clearly in dark ink

**SENDER'S INFORMATION**

Sender's name and address

Report to be sent FAO

Contact Phone Ext

Purchase order number

Project code

Postcode

**PATIENT/SOURCE INFORMATION**

NHS number

Sex  male  female

Surname Date of birth Age

Forename Patient's postcode

Hospital number Ward/ clinic name

Hospital name (if different from sender's name) Ward type

Medico-legal case

**SAMPLE INFORMATION**

Your reference

Sample type

Rectal swab  Throat swab

High vaginal swab  Eye swab

Urethral swab  Cervical swab

Other (please specify)

Date of collection Time

Date sent to PHE

Priority status

Do you suspect that the isolate you are referring could be Hazard Group 3?  Yes  No

Please provide preliminary ID and laboratory results

STBRU are willing to receive, for reference purposes, possible strains of *Neisseria gonorrhoeae* giving anomalous results in identification tests or isolates suspected of exhibiting resistance to third generation cephalosporins or azithromycin. (STBRU will also accept isolates of *N. gonorrhoeae* for confirmation for medico-legal purposes, which are chargeable)

**TESTS REQUESTED**

Reason for Referral

ID to confirm anomalous results  Susceptibility testing (Ceftriaxone/cefixime/azithromycin)

ID to confirm for Medico-legal results  Other (please specify)

**SENDER'S LABORATORY RESULTS**

EM  Enterovirus detection  Rotavirus detection

Norovirus detection  Enterovirus characterisation  Other (please specify)

**CLINICAL/EPIDEMIOLOGICAL INFORMATION**

Clinical details

Abdominal pain  Enteritis  Sporadic case  Household

Diarrhoea  Guillain Barré syndrome  Community  Residential care  Hospital

Other (please specify)

Recent foreign travel?  Yes  No

Antibiotic treatment

**OTHER COMMENTS**

**REFERRED BY**

Name Signature Date

All requests are subject to PHE standards and conditions. Version effective from Apr - 2014 BRC00148.01

### Notes:

**!!** Information required for health and safety reasons

**†** Information required which will appear on your report

**††** Data items that will also be quoted on any invoices you receive for the work being requested

**Referred by**

If requested, please ensure that the request form is signed off by the appropriate person