B5

PHE Microbiology request form

Public Health England

Chlamydia trachomatis Culture Service

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

Postcode

Report to be sent FAO

Contact Phone Ext

Purchase order number

Project code

PATIENT/SOURCE INFORMATION

NHS number

Surname

Forename

Sex ☐ male ☐ female

Date of birth Age

Patient's postcode

Patient's HPT

Hospital number

Hospital name *(if different from sender's name)*

Ward/ clinic name

Ward type

☐ Medico-legal case

SAMPLE INFORMATION

Your reference

Sample type

☐ Urethral swab ☐ Cervical swab ☐ Rectal

☐ *Other *(please specify)*

Date of collection D D M M Y Y Time

Date sent to PHE D D M M Y Y

Priority status

Do you suspect from clinical or lab information that patient is infected with Hazard Group 3 or 4 pathogen?

If yes, give all relevant details

Note: If infection with a Hazard Group 4 pathogen is suspected, from clinical information or travel history, **you must** contact Reference Lab **before** sending

Referring GUM Clinician

Referring GUM Clinic

Buffer used

☐ 2SP Transport medium (*supplied by STBRU*)

☐ Other *(please specify)*

Samples accepted STBRU will accept specimens from patients with persistent infections who have failed treatment with first-line therapeutic regimes (Azithromycin or Doxycycline) on at least two occasions and have been confirmed as C. trachomatis positive at the local laboratory. STBRU will not accept swabs which have been stored for extended periods of time at inappropriate temperatures.

For further information please refer to the Culture Service Guidelines available on the STBRU website or contact STBRU directly.

STBRU ***must*** be contacted prior to shipment of any specimens for the culture service. Any specimens received without prior notification will not be tested and the referral laboratory will be charged.

SENDER'S LABORATORY RESULTS

Primary results ☐ Positive ☐ Negative Kit used *(please specify)*

Repeat results ☐ Positive ☐ Negative Kit used *(please specify)*

Was repeat on fresh specimen ☐ Yes ☐ No

CLINICAL/EPIDEMIOLOGICAL INFORMATION

Symptoms (brief description of)

Date of onset D D M M Y Y

☐ Azithromycin	Dose	Comments
☐ Doxycycline	Dose	Comments
☐ Other *(please specify)*	Dose	Comments

OTHER COMMENTS

REFERRED BY

Name Signature Date D D M M Y Y