B3

UKHSA Microbiology request form

UK Health Security Agency

Syphilis/Chancroid Referral

STI Reference Laboratory (STIRL)
61 Colindale Avenue
London NW9 5HT

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

UKHSA Colindale(BRD)
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

ODS 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)*

Have previous samples been sent to UKHSA ☐ Yes ☐ No

ODS code where sample collected

Ward/ clinic name

Ward type

UKHSA reference number

☐ Medico-legal case

SAMPLE INFORMATION

Your reference

Sample type

☐ Serum ☐ CSF *(should be sent with a paired serum sample)*

☐ Swab *(please specify)*

☐ Other *(please specify)*

Date of collection D D M M Y Y Time

Date sent to UKHSA D D M M Y Y

Priority status

Do you suspect from clinical or lab information that patient is infected with a Hazard Group 3 or 4 pathogen (excluding HIV)?

☐ Group3 ☐ Group4 ☐ No ☐ Unknown

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

STIRL will accept serum and CSF for confirmation of serological diagnosis of syphilis, and swabs for molecular detection of *Treponema pallidum* and *Haemophilus ducreyi*. ☐

SENDER'S LABORATORY RESULTS

Please enter laboratory results that initiated referral

☐ Positive ☐ Negative ☐ Equivocal Kit used

☐ Positive ☐ Negative ☐ Equivocal Kit used

☐ Positive ☐ Negative ☐ Equivocal Kit used

For CSF samples please enter

CSF WCC:

CSF Protein:

CLINICAL/EPIDEMIOLOGICAL INFORMATION

Clinical signs

☐ Ulcer
☐ Rash
☐ Lymphadenopathy
☐ Neurological symptons
☐ Other *(please specify)*

☐ No Symptoms
☐ Recent exposure
☐ Previous syphilis
☐ HIV positive

Please specify *(if known)*

Patient group from which sample was derived

☐ GUM attendee / Sexual health screen
☐ Antenatal screen Weeks
☐ Dementia screen
☐ GP patient
☐ Other *(please specify)*

☐ Maternal transmission (mother HIV positive)
☐ Maternal transmission (mother's HIV status unknown)

OTHER COMMENTS

REFERRED BY

Name Signature Date D D M M Y Y