



Please write clearly in dark ink

SENDER'S INFORMATION

Sender's name and address

Direct Phone

Direct Phone (out of hours)

Postcode

PATIENT/SOURCE INFORMATION

 Inpatient Outpatient GP Patient Other*

*Please specify

NHS number

Surname

Forename

Hospital number

Hospital name (if different from sender's name)

Gender male female

Date of birth | D | D | M | M | Y | Y | Y | Y | Age

Patient's postcode

Patient's HPT

 ITU Other ward/clinic:Pregnant Yes No Unknown WeeksHave previous samples been sent to RIPL? Yes No

RIPL Lab ref. no P _ _ C _ _ _ _ _

SAMPLE INFORMATION

Sample type

 Serum (clotted blood) Plasma EDTA whole blood CSF (Supply with paired serum) Joint fluid Tissue (please specify site and type) Other (please specify)

Your reference

Date of collection | D | D | M | M | Y | Y | Time

Date sent to RIPL | D | D | M | M | Y | Y

For CSF sample testing, please refer to Lyme section (Appendix 1) in the RIPL user manual and provide these data if available.

Serum		CSF
Albumin	g/L	mg/L
IgM	g/L	mg/L
IgG	g/L	mg/L
		WCC
		cells/mm ³

RIPL can offer additional tests and advice for other infections acquired abroad or related to tick bites, if clinically relevant.

Clinicians should discuss this with RIPL.

Please tick the box if your clinical sample is post mortem

TESTS REQUESTED See RIPL Lyme webpage on GOV.UK

RIPL will select most appropriate tests based on clinical history provided below.

 Line blot confirmation only

Refer to Lyme section (Appendix 1) in RIPL user manual for further details.

SENDER'S LABORATORY RESULTS

Has the patient had a previous Lyme test? Yes No

Results

Date of test | D | D | M | M | Y | Y

CLINICAL/EPIDEMIOLOGICAL INFORMATION

Clinical details

 History of tick bite Date of bite | D | D | M | M | Y | Y

Where was the patient when bitten? (Country/UK area)

Date of onset of current symptoms | D | D | M | M | Y | Y

Relevant occupational or other exposure history

Any other travel history

Treatment History

Antimicrobials given and duration

Clinical features

 Erythema migrans (please specify date of onset and site) Other rash (please specify date of onset and site) Fatigue Myalgia Arthralgia Headache Fever Neurological symptoms (please specify) Lymphadenopathy Uveitis/episcleritis/keratitis/vitreitis Meningitis Carditis Arthritis Lymphocytoma Acrodermatitis Other clinical features (please specify)

Comments

REFERRED BY

Name

Signature

Date | D | D | M | M | Y | Y