L5

UKHSA Microbiology request form

UK Health Security Agency

Please write clearly in dark ink

Gastrointestinal Bacteria Referral Clinical Specimen *(For cultures please use Form L4)*

C. botulinum*, *C. perfringens*, *C. tetani*, *E. coli* and *Helicobacter

Bacteriology Reference Department
GBRU
61 Colindale Avenue
London NW9 5HT

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

UKHSA Colindale
Bacteriology
DX 6530002
Colindale NW

SENDER'S INFORMATION

Sender's name and address

Postcode

Report to be sent FAO

Contact Phone Ext

Purchase order number

Project code

Outbreak/investigation

ILog number

PATIENT/SOURCE INFORMATION

☐ Human ☐ Animal* ☐ Other*

☐ Inpatient ☐ Outpatient ☐ GP Patient ☐ Other*

*Please specify

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

SAMPLE INFORMATION

Your reference

Date of collection Time am/pm

Date sent to UKHSA

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

☐ Yes - Group3 ☐ Yes - Group4 ☐ No

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

Sample details

☐ Biopsy (*Helicobacter* only) ☐ Faeces (STEC, *C. botulinum* & *C. perfringens* enterotoxin only) ☐ Rectal swab (STEC only) ☐ Serum (*C. botulinum* only)

TESTS REQUESTED

☐ *C. botulinum* ☐ *C. perfringens* enterotoxin ☐ *C. tetani* ☐ *E. coli* O157/STEC ☐ *Helicobacter*

☐ Other *(please specify)*

CLINICAL/EPIDEMIOLOGICAL INFORMATION

Clinical details

☐ Abdominal pain
☐ Asymptomatic
☐ Constipation
☐ Diarrhoea
☐ Diarrhoea (Bloody)
☐ Diarrhoea (Watery)
☐ Encephalitis
☐ Enteritis
☐ Fatal ☐ Post-mortem sample
☐ Guillain Barré syndrome
☐ HUS
☐ Meningitis
☐ Neurological symptoms *(please provide details below)*
☐ Pyrexia/Fever
☐ Septicaemia
☐ Vomiting

☐ Other *(please specify)*

Date of onset Time am/pm

Duration of symptoms:

☐ Renal dialysis ☐ Recent blood transfusion

Antibiotic treatment

Vaccination history

Outbreak Type

☐ General ☐ Household ☐ Sporadic case

Outbreak details

No. of symptomatic people:

Recent foreign travel? ☐ Yes ☐ No

Countries visited in past 4 weeks:

OTHER COMMENTS