E11

UKHSA Microbiology request form

UK Health Security Agency

Varicella Zoster Virus

Virus Reference Department
61 Colindale Avenue
London NW9 5HT

Phone+44 (0)20 8327 6017/7887
VRDqueries@ukhsa.gov.uk
www.gov.uk/ukhsa

UKHSA Colindale
(VRD)
DX6530006
Colindale NW

Please write clearly in black ink

SENDER'S INFORMATION

Report to be sent FAO

Contact Phone Ext

Purchase order number

Project code

Postcode

PATIENT/SOURCE INFORMATION

☐ Inpatient ☐ Outpatient ☐ GP Patient

NHS number

Sex ☐ male ☐ female

Surname

Date of birth Age

Forename

Patient's postcode

Patient's HPT

Hospital number

Ward/ clinic name

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

Ward type

Pregnant ☐ Yes ☐ No ☐ Unknown Weeks

SAMPLE INFORMATION

Your reference

Sample type

☐ Vesicle Swab ☐ Vesicle Fluid ☐ CSF ☐ Plasma

☐ Viral isolate ☐ DNA ☐ Scab ☐ *Serum

*Please note: Only serum can be used for IgM testing

☐ Other *(please specify)*

Date of collection Time

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

Please tick the box if your clinical sample is post mortem ☐

Date sent to UKHSA

TESTS REQUESTED

☐ VZV IgG ☐ VZV DNA

☐ VZV IgM+IgG (IgM will only be performed if IgG is negative and clinical information is provided below)

CLINICAL/EPIDEMIOLOGICAL INFORMATION

☐ Pre vaccine screening ☐ Post exposure ☐ Confirmation of VZV infection or re-activation

If this is a vaccine related query please fill in the following section, otherwise please fill in the non-vaccine related section

Vaccine related samples

☐ Post vaccine

☐ Varicella vaccine e.g.MMRV 1st dose Date

☐ Varicella vaccine 2nd dose Date

☐ Zostavax (NOT Shingrix) Date

Date

Date

Date

Nature of rash *(if present)*

☐ At vaccine inoculation site

☐ Localised away from vaccine inoculation site

☐ Generalised

☐ Other *(Please give details)*

Date of onset

Date of contact

OTHER CLINICAL DETAILS *(eg immunosupression)*