National Virus Reference Laboratory
University College Dublin
Belfield, Dublin 4

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Respiratory Virus REQUEST FORM

PATIENT DETAILS

Forename:

DOB: D D / M M / Y Y Y Y

Surname:

Sex : F M

Patient/Guardian Address (Including Eircode):

NB: Please note that both the sample and the test request form must detail the patient's name and Date Of Birth

Patient/Guardian Mobile Number

Swift Queue Refer Number

NB: A mobile number is essential

SPECIMEN DETAILS

Specimen Type:

Combined Oropharyngeal/ Nasopharyngeal swab

Nasal Swab *Throat swab*

Specimen Date & Time of collection: D D / M M / Y Y Y Y

H H : M M

REQUESTING DETAILS

SAMPLE COLLECTED BY:

Name:

Signature:

Date: D D / M M / Y Y Y Y

Relevant Clinical Details

GP Name : _____

_____

PHONE NUMBER: _____

ADDRESS: _____

_____

_____

_____

_____

Nursing Home/ GP Practice Stamp