



LYME BORRELIOSIS REQUEST FORM

PATIENT DETAILS

Forename:

DOB:

Surname:

Sex : F M

Address:

SPECIMEN DETAILS

Specimen Type(s): Serum Plasma Other:

Specimen Date & Time of collection:

CLINICAL DETAILS

Tick Exposure Risk (including date of bite if known)

Duration of Symptoms

Erythema migrans (specify date of onset & site)

- Fatigue Arthralgia
 Myalgia Headache
 Fever Arthritis
 Lymphadenopathy Carditis
 Uveitis/episcleritis/keratitis/vitreitis
 Acrodermatitis

It is ESSENTIAL to provide adequate clinical details to aid in test selection and interpretation of results.

Neurological Symptoms (please specify)

Please note CSF samples WILL NOT be tested without accompanying serum sample and adequate clinical information.

CSF findings (if available)

Treatment

DOCTOR / SURGERY DETAILS/REQUESTING HOSPITAL DETAILS

Name:

Signature:

IMC No:

Date:

Tel:

Surgery Address / Hospital Address/Stamp

N.B. Please note that the sample will not be processed without address of surgery or hospital