



National Virus Reference Laboratory
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GENERAL REQUEST FORM

PATIENT DETAILS

Forename:

DOB:

Surname:

Sex :

Address:

Hospital Number:

Lab Number:

SPECIMEN DETAILS

Specimen Type(s): Serum Plasma Other:

Specimen Date & Time of collection:

Sample Collection Details

Sample taken By: Signature: Date taken:

CLINICAL DETAILS

Clinical details aid the selection of an optimal testing strategy. Please include duration of illness and relevant vaccination/travel history

Clinical Details

Date of onset of symptoms:

INVESTIGATION REQUIRED

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