National Virus Reference Laboratory
University College Dublin
Belfield, Dublin 4

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GENERAL REQUEST FORM

PATIENT DETAILS

Forename:

DOB: D D M M Y Y Y Y

Surname:

Sex : F M

Address:

Hospital Number

Lab Number

SPECIMEN DETAILS

Specimen Type(s): Serum Plasma

Other:

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

H H M M

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 D D M M Y Y Y Y

INVESTIGATION REQUIRED

DOCTOR / SURGERY DETAILS/REQUESTING HOSPITAL DETAILS

Name:

Signature:

IMC No:

Date: D D M M Y Y Y Y

Tel:

Surgery Address / Hospital Address/Stamp

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