National Virus Reference Laboratory
University College Dublin
Belfield, Dublin 4

Tel General Enquiries: 01 7164401
Web: nvrl.ucd.ie
Email: nvrl@ucd.ie

STI INVESTIGATION REQUEST FORM

PATIENT DETAILS

Forename:

DOB: D D M M Y Y Y Y

Surname:

Sex : F M

Address: Mandatory

Hospital Number (Mandatory if available)

Lab Number (Mandatory if available)

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.

Date of onset of symptoms D D M M Y Y Y Y

Clinical Details

SWAB SITE

HVS ECS Rectal

LVS Throat Other

INVESTIGATION REQUIRED

Viral Serology Investigations

HIV .....

HBsAg .....

anti-HBcore .....

anti-HBs .....

Hepatitis C .....

Syphilis .....

Other (please specify) .....

Molecular Investigations

Chlamydia .....

Trichomonas .....

Neisseria gonorrhoea .....

Mycoplasma genitalium .....

Herpes simplex virus .....

DOCTOR/SURGERY/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