LYME BORRELIOSIS REQUEST FORM

PATIENT DETAILS
Forename: ___________________________ DOB: DD MM YYYY
Surname: ___________________________ Sex: F M
Address: ___________________________

SPECIMEN DETAILS
Specimen Type(s): Serum Plasma Other: _______________
Specimen Date & Time of collection: DD MM YYYY HH MM

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 □

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

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

DOCTOR / SURGERY DETAILS/REQUESTING HOSPITAL DETAILS
Name: ___________________________
Signature: ________________________
IMC No: __________________________
Date: DD MM YYYY
Tel: ___________________________

Surgery Address / Hospital Address/Stamp
N.B. Please note that the sample will not be processed without address of surgery or hospital

This is a controlled document