National Virus Reference Laboratory
University College Dublin
Belfield, Dublin 4

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LYME BORRELIOSIS REQUEST FORM

PATIENT DETAILS

Forename:

Surname:

Address:

DOB: D D M M Y Y Y Y

Sex : F M

Hospital Number

Hospital 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

CLINICAL DETAILS

Tick Exposure Risk (including date of bite if known)

Duration of Symptoms

Erythema migrans (specifiy 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 intepretation 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: 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