National Virus Reference Laboratory
University College Dublin
Belfield, Dublin 4

Tel General Enquiries: 01 716 4401
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:

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

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(s):

HVS ☐ Throat ☐

LVS ☐ Rectal ☐

ECS ☐ Other _____

INVESTIGATION REQUIRED (For sample collection requirements please refer to the NVRL User Manual (nvrl.ucd.ie))

Virus Serology Investigations

HIV …….. ☐

HBsAg …… ☐

anti-Hbcore …… ☐

anti-HBs …….. ☐

Hepatitis C …… ☐

Syphilis …….. ☐

Other (please specify) _____

Molecular Investigations — **Specimen type:**

Chlamydia trachomatis and Neisseria gonnorhoeae ☐ **APTIMA**

Trichomonas Vaginalis …… ☐ **APTIMA**

Mycoplasma Genitalium …… ☐ **APTIMA**

Herpes Simplex Virus …… ☐ **Viral swab**

Electron Microscopy

Molluscum contagiosum (scrapings/vesicle fluid only) ☐

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