



## STI INVESTIGATION REQUEST FORM

### PATIENT DETAILS

Forename:  DOB:

Surname:  Sex :

Address:

### SPECIMEN DETAILS

Specimen Type(s):  Serum  Plasma  Other:

Specimen Date & Time of collection:

### Collection Details

Sample collected by  Signature

### CLINICAL DETAILS

Clinical details aid the selection of an optimal testing strategy.

Date of onset of symptoms:

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](http://nvrl.ucd.ie)))

#### Viral Serology Investigations

HIV .....   
 HBsAg .....   
 anti-Hbcore .....   
 anti-HBs .....   
 Hepatitis C .....   
 Syphilis .....   
 Other (please specify) \_\_\_\_\_

#### Molecular Investigations

Chlamydia trachomatis and Neisseria gonorrhoeae  **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:

Tel:

#### Surgery Address / Hospital Address/Stamp

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