

VIROLOGY REQUEST FORM

AFFIX PRINTED LABEL	SENDER / REPORTING DETAILS / GP PRACTICE LABEL
CHI NUMBER * <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	Return report to: GP / Hospital Dept / Ward GP / Consultant <div style="display: flex; justify-content: space-between; width: 100%;"> Name <input style="width: 30px; height: 20px;" type="text"/> </div> Consultant Code
DOB * <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
SURNAME * <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
FORENAME * <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	Requestor Bleep/Tel
SEX * <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> PRIVATE <input type="checkbox"/> NHS
POSTCODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
* Denotes Mandatory Data Set Please state postcode if CHI unavailable	

SPECIMEN DETAILS	INVESTIGATIONS REQUIRED	LAB USE ONLY
Date collected / / <input type="checkbox"/> Swab in VTM Nose / Throat / Eye / Genital Other: <input type="checkbox"/> Blood (Clotted) <input type="checkbox"/> Blood (EDTA) <input type="checkbox"/> Faeces (Virology only) <input type="checkbox"/> Other (Please specify) <input type="checkbox"/> Chlamydia / Gonorrhoea DNA <input type="checkbox"/> 1st void urine <input type="checkbox"/> Endocervical swab <input type="checkbox"/> Self taken vaginal swab (SOLVS) <input type="checkbox"/> Other swab (Please specify) Previous sample Lab No.:	<input type="checkbox"/> Acute hepatitis <input type="checkbox"/> Lymphadenopathy / Glandular fever (EBV / CMV / Toxo) <input type="checkbox"/> VZV (past infection) <input type="checkbox"/> Helicobacter pylori <input type="checkbox"/> Other: Immunisation check - HBV <input type="checkbox"/> Pre vaccine - HBcAb <input type="checkbox"/> Post vaccine - Anti HBs Date of last dose: / / Additional Information <input type="checkbox"/> Heterosexual <input type="checkbox"/> MSM <input type="checkbox"/> IVDU <input type="checkbox"/> Other: (specify) CLINICAL DETAILS / SYMPTOMS Date of Contact / Onset of Illness / / <input type="checkbox"/> Fever <input type="checkbox"/> URTI <input type="checkbox"/> LRTI <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Conjunctivitis Rash: <input type="checkbox"/> Vesicular <input type="checkbox"/> Non-vesicular <input type="checkbox"/> Pregnant: gestation / 40 <input type="checkbox"/> Immunosuppressed <input type="checkbox"/> Occupational risk <input type="checkbox"/> Travel abroad: Return date / / Destination(s) <input type="checkbox"/> Vaccination: YF / Chickenpox / Other <input type="checkbox"/> Other (Please specify)	

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