

Lymphogranuloma Venereum (LGV) PCR

Scottish Bacterial Sexually Transmitted Infections Reference Laboratory
(SBSTIRL)

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FROM
Consultant
Referring lab
Address
Telephone number

PATIENT DETAILS

Surname: Forename:

Clinic number / CHI: Date of Birth:

Sex: M / F / U

Category of patient: GUM GP Hospital Other

If Health Board of sample collection differs from referring lab please specify:

OR SH WI Other

SPECIMEN

Your lab number:

Date collected: Date sent to SBSTIRL:

Sample type: Urethral Cervical
 Urine Vulvo/vaginal
 Rectal Throat
 Other (please specify)

TESTING

REFERRED SAMPLES MUST BE *CHLAMYDIA TRACHOMATIS* POSITIVE

Screening *Chlamydia trachomatis* NAAT test used:

Abbott Alinity m STI Hologic Aptima Combo 2
 Abbott M2000 CT/NG Qiagen Artus CT/NG QS-RGQ
 BD Probetec ET CT/GC Roche Cobas CT/NG
 Cepheid Xpert CT/NG Other (please specify)

Ct/Cq/DC/RLU/other test value:

REASON FOR REQUEST

Symptomatic Proctitis
 Inguinal lymphadenopathy
 Other (please specify)
 Contact of confirmed LGV case
 Chlamydia trachomatis positive sample from HIV positive MSM