# National Gonococcal Reference Laboratory

MICROBIOLOGY DEPARTMENT C.P.L. ST JAMES HOSPITAL, DUBLIN 8

TEL. 00353 1 4162941/ 00353 1 4162966/ 00353 12967

*An INAB accredited Medical testing laboratory, Registration Number 327MT*

FOR SJH LAB USE ONLY
PLEASE AFFIX SPECIMEN

## Sender's Information

**Consultant Name**

**Referrer's address**

**Contact Number:**

**ALL DETAILS ARE REQUIRED**
AND MUST BE FILLED.

SPECIMEN RECEIVED WITH INCOMPLETE REQUEST FORM WILL NOT BE PROCESSED

## PATIENT INFORMATION *(All details are required)*

**Surname**

**Forename**

**Patient Address**

*County* _____ *Eircode (if available)*

**Date of birth** D D M M Y Y

**Sex** (at birth) ◯ FEMALE ◯ MALE

**Hospital No.** _____ **Referrer's Lab. No.** _____

## SPECIMEN INFORMATION

**Isolate site:**

◯ Urethral ◯ Vaginal

◯ Rectal ◯ Cervical

◯ Pharyngeal ◯ Eye

◯ Others (*please specify below*)

**Date of Collection:** D D M M Y Y

**Date of isolation:** D D M M Y Y

**Date and time dispatched to SJH:** D D M M Y Y H H Y Y

NB: *please indicate*
**IF MEDICO LEGAL CASE**

◯ YES ◯ NO

*If yes, please notify the National Gonococcal Reference laboratory before sending*

## TEST REQUESTED

**Reason(s) for referral** *(tick all required test)* :

◯ To confirm *N. gonorrhoeae* identification

◯ To perform full *N. gonorrhoeae* antimicrobial susceptibility testing

◯ To confirm *N. gonorrhoeae* isolate has reduced susceptibility to third generation cephalosporins and/or high level Azithromycin resistance

◯ Outbreak investigations (WGS available on request) Please contact laboratory prior to sending isolates

## SENDER'S LABORATORY RESULTS

**Presumptive identification:** *(specify method used)*

**Susceptibility result:** *(specify method used)*