Gonococcal Reference laboratory

MICROBIOLOGY DEPARMENT,C.P.L. ST JAMES HOSPITAL,DUBLIN 8
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ST. JAMES'S HOSPITAL

An INAB accredited Medical testing Laboratory, Registration Number 327MT

FOR LAB USE ONLY
PLEASE AFFIX SPECIMEN NUMBER BARCODE LABEL HERE

Please fill out all sections and use capital block letters

SENDER'S INFORMATION

Sender's name and address

Report to be sent FAO

Hospital name *(if different from sender's name)*

Service type : □ STI clinic □ GP □ Others:

Contact Number:

PATIENT/SOURCE INFORMATION

Surname

Forename

Hospital No.

Lab No.

Date of birth D D M M Y Y

Sex ☐ Female ☐ Male ☐ Unspecified

Country of birth

Country of residence

Country of infection

Antibiotic(s) used for treatment:

Transmission ☐ Heterosexual ☐ MSM

Foreign travel? ☐ YES ☐ NO

Previous gonococcal infection? ☐ YES ☐ NO

concurrent STI? ☐ YES ☐ NO

If yes, please specify here:

ISOLATE INFORMATION

Isolate site:

□ Urethral □Vaginal
□ Rectal □Cervical
□ Pharyngeal □ Eye
□ Others *(specify)*

Date of collection D D M M Y Y
Date of isolation D D M M Y Y
Date and Time sent to SJH D D M M Y Y H H M M

NB: *please indicate*
IF MEDICO LEGAL CASE
☐ YES ☐ NO

TEST REQUESTED

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

□ To confirm *N. gonorrhoeae* identification

□ To perform routine *N. gonorrhoeae* full Antimicrobial susceptibility testing

□ To confirm *N. gonorrhoeae* isolates tested in sender's laboratory have reduced susceptibility to third generation cephalosporins and/or with high level Azithromycin resistance

SENDER'S LABORATORY RESULTS

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

Susceptibility result / MIC result: (*specify method(s) used)*

Antibiotic	MIC	Interpretation

REFERRED BY (*Name and Signature):*

Time and date: