



National Gonococcal Reference Laboratory

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

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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

Date of Collection:

D D M M Y Y

☐ Rectal ☐ Cervical

Date of isolation:

D D M M Y Y

☐ Pharyngeal ☐ Eye

Date and time
dispatched to SJH:

D D M M Y Y

☐ Others (please specify below)

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)