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

ISO 15189 INAB ACCREDITED TESTING DETAILED IN SCOPE REG NO.231MT

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)*