

**LAB USE ONLY: LAB NO:**

**SEL Pathology Offline Request Form**

**For use only if online request is not possible**

**Microbiology**

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| **Patient Details** |
| **Surname:**       | **First name:**       |
| **Date of Birth:**       | **NHS No:**       | **Sex:**       |
| **Landline:**       | **Mobile:**       |
| **Email:**       |  |

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| **Requestor Details** |
| **Practice/Organisation name:**       |
| **Address:**       |
| **Telephone:**       | **Email:**       |
| **Form completed by:**       **on behalf of:**       |
| **MANDATORY ORGANISATION APEX CODE:**        |
| **Professional Registration Number e.g. GMC/NMC number** (Results will be returned unmatched if this is not provided)**:**       |

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| **Urine MC&S** |
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| **Sample type:** | [ ]  MSU | [ ]  CSU | [ ]  Other - state type:       |

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| **Stool** |
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| **Tests requested:** | [ ]  MC&S | [ ]  C. Difficile | [ ]  H. Pylori Antigen | [ ]  Parasitology |

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| **Sputum** |
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| **Tests requested:** | [ ]  MC&S | [ ]  Acid Fast Bacilli |  |  |

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| **Chlamydia and Gonorrhoea Swabs** |
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| **Sample Site/type:** | [ ]  Urine | [ ]  Cervix | [ ]  Throat | [ ]  Urethra |
| [ ]  Vaginal (sampled by clinician) | [ ]  Rectum | [ ]  Left eye | [ ]  Right eye |
| [ ]  Vaginal (sampled by patient) | [ ]  Other – specify:       |

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| **MRSA Screening Swabs** |
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| **Site:** | [ ]  Nasal | [ ]  Axilla | [ ]  Groin | [ ]  Other - state site:       |

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| **Swabs (General)** |
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| **Sample Site/type:** | [ ]  High Vaginal | [ ]  Low Vaginal | [ ]  Cervical | [ ]  Penile | [ ]  Throat | [ ]  Left Eye | [ ]  Right Eye |
| [ ]  Left Ear | [ ]  Right Ear | [ ]  Wound - Site:       | [ ]  Skin - Site:       |
| [ ]  Pus/Abscess Site:       | [ ]  Other – specify:       |

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| **Mycology** |
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|  | [ ]  Specify site/type:      |

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| **Other MC&S** |
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| **Sample Site/type:** | [ ]  Fluid - specify site/type:       | [ ]  Tissue - specify site/type:       |
|  |
| [ ]  Other - specify site/type:       |

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| **Clinical Details/Drug Therapy/Antibiotic Therapy- *(This section must be completed)*** |
|       |
| **Signed:** | **Date:**       |
| Specimen LabellingInstructions | Attach patient label or complete the specimen label in BLOCK CAPITALS. The following details are **mandatory**: **First name, surname, DOB, NHS number & Sex** |
| **Specimen collected by:** |  | **Collection Date:**  |  | **Time:** |