

**LAB USE ONLY: LAB NO:**

**SEL Pathology Offline Request Form**

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

**Virology**

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

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Blood Tests | | | Non-Blood Tests | | |
| **SST, Gold topped tube required** | | | **Herpes Simplex Types 1 & 2 DNA &VZV DNA PCR** | | |
|  | HIV 1 & 2 Antibodies and Antigen | |  | Mouth swab | |
|  | Hepatitis A Acute Serology (IgM) | |  | Skin swab | |
|  | Hepatitis B Surface Antigen | |  | Penile swab | |
|  | Hepatitis B Core Antibody | |  | Vulval swab | |
|  | Hepatitis B Surface Antibody | |  | Other (please specify) | |
|  | Hepatitis C Antibody | |  | | |
|  | Hepatitis E Acute Serology (IgM) | | **Respiratory Virus Panel including SARS-CoV-2 (COVID)** | | |
|  | Syphilis Screen | |  | Combined nose and throat swab | |
|  | Measles Status (IgG) | |  |  | |
|  | Mumps Status (IgG) | | **Norovirus Types 1 & 2, Rotavirus, Adenovirus, Sapovirus, Astrovirus** | | |
|  | EBV Serology | |  | Faeces | |
|  | EBV IgM | |  |  | |
|  | EBV IgG | |  |  | |
|  | VZV IgG | |  |  | |
| **EDTA, Purple topped tube required** | | |  | | |
|  | HIV-1 RNA (Viral load) | |  |  | |
|  | HCV RNA (Viral load) | |  |  | |
|  | HBV DNA (Viral load) | |  |  | |
|  | Other (please specify) | |  |  | |
| **Other Tests** | | | | | |
| Please specify: | | | | | |
| **Clinical Details / Drug Therapy / Antibiotic Therapy*- (This section must be completed)*** | | | | | |
|  | | | | | |
| **Signed:** | | | | | **Date:** |
| **Sample Labelling Instructions** | | 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:** |