



Please write clearly in black ink

# Clinical Specimens/Cultures

*Bacillus sp., C.botulinum, C.perfringens, C.tetani, S.aureus and Listeria sp.*

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www.hpa.org.uk/SRMTests

HPA Colindale  
Cfl (FSML)  
DX 6530007  
Colindale NW

## SENDER'S INFORMATION

Sender's name and address

Purchase order number

Project code

HPA outbreak/investigation

ILog no

Postcode

Phone

Ext

## PATIENT/SOURCE INFORMATION

NHS number

Surname

Forename

Sex

male

female

Date of birth

| D | D | M | M | Y | Y | Y | Y | Age

Patient's postcode

Inpatient

Outpatient

GP patient

Other (please specify)

Hospital name (if different from sender's name)

Ward/clinic name

Hospital number

Patient's CCDC

## SAMPLE INFORMATION

Your reference

Sample type

Specimen

Isolate

Specimen details

Blood

Serum

Faeces

CSF

Other (please specify)

Date of collection

| D | D | M | M | Y | Y | Time

Date sent to HPA

| D | D | M | M | Y | Y |

Please state the presumptive identification

Priority status

## TESTS REQUESTED

	Toxin/Gene detection*	Isolation	Identification	Typing
<b>Bacillus sp</b>			<input type="checkbox"/>	
<b>B. cereus</b>			<input type="checkbox"/>	<input type="checkbox"/>
<b>C. botulinum</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C. perfringens</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* Note: Toxin/Gene detection is performed directly in clinical material

	Toxin/Gene detection*	Isolation	Identification	Typing
<b>C. tetani</b>	<input type="checkbox"/>			
<b>Listeria sp</b>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
<b>S. aureus</b>			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (please specify)				

## SENDER'S LABORATORY RESULTS

Organism count (cfu/g)

Other information

## CLINICAL/EPIDEMIOLOGICAL INFORMATION

Diarrhoea

Vomiting

Headache

Abdominal pain

Nausea

Encephalitis

Fever

Rash

Flushing

Meningitis

Septacemia

Other including neurological

Date of onset

| D | D | M | M | Y | Y |

Onset time

am/pm

Duration of symptoms

Number symptomatic

Number exposed

## OTHER COMMENTS