



Health
Protection
Agency

Syphilis/Chancroid Referral

**Sexually Transmitted Bacteria
Reference Laboratory**
61 Colindale Avenue
London NW9 5HT

Phone: +44 (0)20 8327 6464
STBRL@hpa.org.uk
www.hpa.org.uk/SRMTests

HPA Colindale
Cfl (STBRL)
DX 6530014
Colindale NW

Please write clearly in black ink

SENDER'S INFORMATION

Sender's name and address

Purchase order number

Project code

Postcode

Phone

Ext

PATIENT/SOURCE INFORMATION

NHS number

Hospital name (if different from sender's name)

Surname

Ward/clinic name

Forename

Hospital number

Patient's CCDC

Sex

male

female

Medico-legal case

Date of birth | D | D | M | M | Y | Y | Y | Y | Age

Have previous samples been sent to HPA Yes No

Patient's postcode

HPA reference number

SAMPLE INFORMATION

Your reference

Please state the presumptive identification

Sample type

Serum

CSF

Swab (please specify)

Other (please specify)

STBRL will accept serum and CSF for confirmation of serological diagnosis of syphilis, and swabs for molecular detection of *Treponema pallidum* and *Haemophilus ducreyi*.

Date of collection | D | D | M | M | Y | Y | Time

Date sent to HPA | D | D | M | M | Y | Y

Priority status

SENDER'S LABORATORY RESULTS

Please enter laboratory results that initiated referral

Primary results

Positive

Negative

Equivocal

Kit used (please specify)

Positive

Negative

Equivocal

Kit used (please specify)

Positive

Negative

Equivocal

Kit used (please specify)

CLINICAL/EPIDEMIOLOGICAL INFORMATION

Clinical signs Yes No

Please specify (if known)

OTHER COMMENTS

REFERRED BY

Name

Signature

Date

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

All requests are subject to HPA standard terms and conditions, available at www.hpa.org.uk/hpa/standardterms.htm

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