



Please write clearly in dark ink

# Haemophilus Reference Unit

WHO Collaborating Centre for *Haemophilus influenzae*

**Respiratory & Systemic  
Infection Laboratory**  
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www.hpa.org.uk/SRMTTests

HPA Colindale  
Cfl (RSIL)  
DX 6530011  
Colindale NW

## SENDER'S INFORMATION

Sender's name and address

Postcode

### Report to be sent FAO

Contact Phone Ext

### Purchase order number

Project code

HPA outbreak/investigation

Ilog number

## PATIENT/SOURCE INFORMATION

NHS number

Surname

Forename

Sex  male  femaleDate of birth 

D	D	M	M	Y	Y	Y	Y
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 Age

Patient postcode

 Inpatient  Outpatient  GP patient Other (please specify)

Hospital name (if different from sender's name)

Ward/clinic name

Ward type

Hospital number

Patient's HPU

## SAMPLE INFORMATION

 Isolate from blood

Your reference

Date of collection 

D	D	M	M	Y	Y	Time
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 Isolate from CSF

Your reference

Date of collection 

D	D	M	M	Y	Y	Time
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 Isolate from other sterile site\*

\*please specify

Your reference

Date of collection 

D	D	M	M	Y	Y	Time
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**Do you suspect that the isolate you are referring could be  
Hazard Group 3 ?**  Yes  No

Please provide preliminary ID and laboratory results

Please state the presumptive identification

 *Haemophilus influenzae*  *Haemophilus sp*Date sent to HPA 

D	D	M	M	Y	Y
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Priority status

## CLINICAL/ EPIDEMIOLOGICAL/OTHER INFORMATION

Main diagnosis

 Bacteraemia Meningitis Epiglottitis Pneumonia Septic arthritis Cellulitis Other (please specify)Does the patient have any  
predisposing condition(s) Yes  No Unknown If yes (please specify)

Recent travel abroad?

 Yes  No Unknown

Has the patient survived or died?

 Survived  Died Not known

If the patient was born after October 1988

GP name

Consultant Paediatrician/Physician

Address

Hospital (if different from above)

Telephone number

## OTHER COMMENTS

## REFERRED BY

Name

Signature

Date

D	D	M	M	Y	Y
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