



# Neisseria Isolate Referral

**Sexually Transmitted Bacteria Reference Laboratory**  
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 STBRL@hpa.org.uk  
 www.hpa.org.uk/SRMTTests

HPA Colindale  
 CfI (STBRL)  
 DX 6530014  
 Colindale NW

Please write clearly in dark ink

HPA Microbiology request form

## SENDER'S INFORMATION

Sender's name and address

### Report to be sent FAO

Contact Phone Ext

### Purchase order number

Project code

Postcode

## PATIENT/SOURCE INFORMATION

NHS number

Hospital name *(if different from sender's name)*

Surname

Ward/clinic name

Forename

Hospital number

Sex  male  female

Patient's CCDC

Medico-legal case

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

Patient's postcode

## SAMPLE INFORMATION

### Your reference

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

Please provide preliminary ID and laboratory results

Sample type

- Rectal swab  Throat swab  
 High vaginal swab  Eye swab  
 Urethral swab  Cervical swab

Other *(please specify)*

STBRL are willing to receive, for reference purposes, possible isolates of *Neisseria gonorrhoeae* giving anomalous results in identification tests or isolates suspected of exhibiting resistance to third generation cephalosporins or azithromycin. (STBRL will also accept isolates of *N. gonorrhoeae* for confirmation for medico-legal purposes, which are chargeable)

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

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

Priority status

## TESTS REQUESTED

### Reason for Referral

- ID to confirm anomalous results  Susceptibility testing (Celtriaxone/cefixime/azithromycin)  
 ID to confirm for Medico-legal results  Other *(please specify)*

## SENDER'S LABORATORY RESULTS

Please give laboratory results that initiated referral to STBRL

## OTHER COMMENTS

## REFERRED BY

Name

Signature

Date

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