



Please write clearly in dark ink

Helicobacter Referral

Laboratory of Gastrointestinal
Pathogens
61 Colindale Avenue
London NW9 5HT

Phone: +44 (0)20 8327 6111 / 6538
LGP@hpa.org.uk
www.hpa.org.uk/SRMTests

HPA Colindale
Cfl (LGP)
DX 6530008
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

Human Animal*
 Food* Water* Environment* Other*

*Please specify

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

Medico-legal case

SAMPLE INFORMATION

Your reference

Sample type Biopsy Culture
 Faecal sample (complete treatment history)

Other (please specify)

Biopsy site Gastric antrum Gastric corpus
 Duodenum

Other (please specify)

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

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

Do you suspect from clinical or lab information that patient is infected with hazard group 3 or 4 pathogen? Yes No

If yes, give all relevant details Unknown

If referring an isolate, give preliminary ID and lab results

Note: If infection with a Hazard Group 4 pathogen is suspected, from clinical information or travel history, **you must** contact Reference Lab **before** sending

Please state the presumptive identification

Priority status

TESTS REQUESTED

Isolation/ID/Antibiotic susceptibility

PCR (if biopsies culture negative) Stool Antigen test

SENDER'S LABORATORY RESULTS

Please indicate the results of any

Serology tests:

Positive Negative Unknown

H. pylori breath test:

Positive Negative Unknown

CLINICAL/EPIDEMIOLOGICAL INFORMATION

Clinical details

Dyspepsia Gastric cancer
 Peptic ulcer B cell MALT lymphoma

Other (please specify)

Treatment history

Previous *H. pylori* therapy Yes No Not known

If Yes, treatment given:

Completion Date: | D | D | M | M | Y | Y |

Patient has had antacid and/or antibiotic treatment in the last 4 weeks

Yes No Not known

OTHER COMMENTS