



Please write clearly in dark ink

# Mycoplasma genitalium Referral

**Sexually Transmitted Bacteria  
Reference Laboratory**  
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London NW9 5HT

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STBRL@hpa.org.uk  
www.hpa.org.uk/SRMTTests

HPA Colindale  
Cfl (STBRL)  
DX 6530014  
Colindale NW

## SENDER'S INFORMATION

Sender's name and address

Postcode

### Report to be sent FAO

Contact Phone Ext

Purchase order number

Project code

## 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

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

 Urine  Endocervical swab  Rectal swab Genital swab *(please specify)* Extracted DNA *(isolation site)*Extraction method *(if known)* Other sample *(please specify)*

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

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

Priority status

### Do you suspect from clinical or lab information that patient is infected with a Hazard Group 3 or 4 pathogen (excluding HIV)?

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

If storing samples, retain at 4°C. Transport at room temp within 7 days. Use swabs in transport medium excluding charcoal swabs.

**Specimens accepted** STBRL will accept specimens and extracted DNA for *Mycoplasma genitalium* from patients for which clinical signs are given or those with contact of known case.

### Preferred specimens

men: first pass urine

women: first pass urine + endocervical swab

## CLINICAL/EPIDEMIOLOGICAL INFORMATION

If clinical information is not given the specimen will be archived until receipt

Clinical signs  Yes  No*(please specify if known)*Contact of known case  Yes  No

Has the patient received antibiotic therapy in the past 2 months?

 Yes  No  Unknown

If yes, please specify the antibiotics and duration of treatment

## OTHER COMMENTS

## REFERRED BY

Name

Signature

Date