



Please write clearly in black ink

Chlamydia trachomatis Culture Service

**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

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

Patient's postcode

SAMPLE INFORMATION

Your reference

Please state the presumptive identification

Sample type

 Urethral swab Cervical swab Rectal

Referring GUM Clinician

 *Other (please specify)

Referring GUM Clinic

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

Buffer used

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

 2SP Transport medium (supplied by STBRL)

Priority status

 Other (please specify)

Samples accepted STBRL will accept specimens from patients with persistent infections who have failed treatment with a first-line therapeutic regime (Azithromycin or Doxycycline) and have been confirmed as *C. trachomatis* positive at the local laboratory. STBRL will not accept swabs which have been stored for extended periods of time at inappropriate temperatures. For further information please

refer to the Culture Service Guidelines available on the STBRL website or contact STBRL directly.

STBRL **must** be contacted prior to shipment of any specimens for the culture service. Any specimens received without prior notification will not be tested and the referral laboratory will be charged.

SENDER'S LABORATORY RESULTS

Primary results

 Positive Negative

Kit used (please specify)

Repeat results

 Positive Negative

Kit used (please specify)

Was repeat on fresh specimen

 Yes No

CLINICAL/EPIDEMIOLOGICAL INFORMATION

Symptoms (brief description of)

Date of onset | D | D | M | M | Y | Y |

 Azithromycin

Dose

Comments

 Doxycycline

Dose

Comments

 Other (please specify)

Dose

Comments

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

Effective from 18/05/09

CW-0180.01