



Please write clearly in dark ink

Rare and Imported Pathogens Request

Rare and Imported Pathogens Laboratory [this form is NOT for routine Lyme requests]

PHE Microbiology Services
Porton Down, Salisbury
Wiltshire SP4 0JG

Phone +44 (0)1980 612348 (9am - 5pm)
Email ripl@phe.gov.uk
www.gov.uk/phe

PHE
DX 6930400
Salisbury 92 SP

SENDER'S INFORMATION

Sender's name and address	Direct Phone
Postcode	Direct Phone (out of hours)

PATIENT/SOURCE INFORMATION

<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> GP Patient <input type="checkbox"/> Other*	*Please specify
NHS number	Gender <input type="checkbox"/> male <input type="checkbox"/> female
Surname	Date of birth D D M M Y Y Y Y Age
Forename	Patient's postcode
Hospital number	Patient's HPT
Hospital name (if different from sender's name)	<input type="checkbox"/> ITU <input type="checkbox"/> Other ward/clinic:
Have previous samples been sent to RIPL? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Weeks
RIPL Lab ref. no P1 _ CO _ _ _ _ _	

SAMPLE INFORMATION

Sample type	Your reference
<input type="checkbox"/> Serum \clotted blood	
<input type="checkbox"/> Plasma	
<input type="checkbox"/> EDTA whole blood	
<input type="checkbox"/> CSF	
<input type="checkbox"/> Other (please specify)	
Date of collection D D M M Y Y Time	
Date sent to RIPL D D M M Y Y	

If Viral Haemorrhagic Fever (or infection with another Hazard Group 4 pathogen) is suspected, the Infectious Diseases, Microbiology or Virology doctor must call the Imported Fever Service on

0844 77 88 990

This number can be used for urgent clinical discussion of any patient with acute undiagnosed fever following recent travel abroad

Please tick the box if your clinical sample is post mortem

TESTS REQUESTED

Based on the clinical details, RIPL will test against a panel of agents by serology +/- PCR at a **lower cost** than any two individual tests. If you do **NOT** want this service, tick the box and state your requirements.

CLINICAL/EPIDEMIOLOGICAL INFORMATION

<p>Foreign Travel within previous 21days? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Purpose of travel</p> <p>Date of travel (from UK) D D M M Y Y </p> <p>Date returned (to UK) D D M M Y Y </p> <p>Onset date D D M M Y Y </p> <p>Countries/areas visited</p> <p><input type="checkbox"/> Mosquito bite <input type="checkbox"/> Tick bite <input type="checkbox"/> Other insect bite*</p> <p><input type="checkbox"/> Livestock exposure <input type="checkbox"/> Other exposure*</p> <p>*Please specify</p> <p>Travel Vaccination History</p> <p>Relevant Occupational History</p>	<p><input type="checkbox"/> Arthralgia</p> <p><input type="checkbox"/> Encephalitis</p> <p><input type="checkbox"/> Endocarditis</p> <p><input type="checkbox"/> Eschar</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Haemorrhage</p> <p><input type="checkbox"/> Leucopenia</p> <p><input type="checkbox"/> LFTs raised</p> <p><input type="checkbox"/> Lymphocytosis</p> <p><input type="checkbox"/> Meningitis</p> <p><input type="checkbox"/> Myalgia</p> <p><input type="checkbox"/> Neutrophilia</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Respiratory symptoms</p> <p><input type="checkbox"/> Retro-orbital pain</p> <p><input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> Thrombocytopenia</p>
	<p>Other clinical details</p> <p>Any unusual activities?</p> <p>Suspected Diagnosis?</p> <p>Antimicrobials given?</p>

REFERRED BY

Name	Signature	Date D D M M Y Y
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