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| Author/Reviewer | SA Feeney | Authoriser | T Curran |
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| Effective Date | 31/03/2023 | Document Type | **Virology Request Form** |
| **Congenital Syphilis Request Form MOTHER** | | | |

**Send to: REGIONAL VIRUS LABORATORY, Kelvin Building, Royal Group of Hospitals Trust, Grosvenor Road, Belfast BT12 6BA. Duty Virologist: 07889 086946 (9am-5.30pm Mon-Fri)**

AFFIX LABEL OR ENTER DETAILS LEGIBLY

| **Forename/Initial** | **Surname/Initial** | **D.O.B** | **Male/Female** |
|---|---|---|---|
| | | **Hospital No.** | |
| | | **Hospital** | **Consultant /GP** |
| | | **Ward / Clinic** | |

****Please send this sample of maternal blood (Serum) separate from infant blood (Serum)****
****5ML CLOTTED BLOOD/SERUM – YELLOW OR RED TOP BLOOD TUBE****
****DO NOT SEND CORD BLOOD ****

## Maternal Blood

THIS IS A **DELIVERY SAMPLE** . YES # ☐ SYPHILIS SEROLOGY TESTING **[BTPT SYCO TPLT TPM]**

**If not yet delivered Gestation stage** _____

**# Maternal sample must be taken no more than 4 weeks before infant**

OR THIS IS A **FOLLOW-UP SAMPLE** YES* ☐ SYPHILIS FOLLOW UP SEROLOGY **[BTPT SYCO]**

*** Follow-up stage post-delivery (wks or mths)** _____

**PLEASE COMPLETE BELOW**

| | | | | |
|---|---|---|---|---|
| Previous known Syphilis | ☐ | YES | ☐ | NO |
| Record of Treatment | ☐ | YES | ☐ | NO |
| Infant sample sent at this time | ☐ | YES | ☐ | NO |

| **Specimen Date & Time** | **Lab use** |
|---|---|
| **Signature** | |

- **Take care that no blood contaminates the outside of the tube.**
- **Specimens should be packaged as per the laboratory user manual.**
- **Ensure specimen container lids are well secured to prevent leakage in transit.**