Revision Number	1.0	Document Number	M-2478
Author/Reviewer	SA Feeney	Authoriser	T Curran
Active Date	31/03/2023	Page Number	Page 1 of 1
Effective Date	31/03/2023	Document Type	**Virology Request Form**
Congenital Syphilis Request Form INFANT			

Send to: REGIONAL VIRUS LABORATORY, Kelvin Building, Royal Group of Hospitals Trust, Grosvenor Road, Belfast BT12 6BA. DutyVirologist 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 INFANT blood (Serum) separate from MOTHER blood (Serum)****
****2ml PAEDIATRIC SERUM – YELLOW OR RED TOP BLOOD TUBE** **DO NOT SEND CORD BLOOD ****

Infant Blood

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

OR THIS IS A **FOLLOW-UP SAMPLE** YES* ☐ SYPHILIS FOLLOW UP SEROLOGY AS BELOW

1 Month (RPR IgM) [SYCO TPM] ☐ 3 Month (RPR IgM) [SYCO TPM] ☐

6 Months (RPR) [SYCO] ☐ 12 Months (RPR) [SYCO] ☐

MOTHER sample sent at this time YES ☐ NO ☐

Specimen type 2ml PAEDSerum	**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.**