Revision Number	3.0	Document Number	M-2477
Author/Reviewer	S. Feeney	Authoriser	K. Li
Active Date	04/06/2024	Page Number	Page 1 of 1
Effective Date	04/06/2024	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	**HCP Code AND Consultant**
		Ward / Clinic / Source code	

****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 **[SYPT MATERNAL/LONG TITRATION]**

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 **[SYPT MATERNAL/FOLLOW UP]**

*** 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.**