Revision Number	3.0	Document Number	M-2478
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 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**
Address:		**Hospital No.**	
		Hospital	**HCP Code AND Consultant /GP**
		Ward / Clinic / Source Code	

****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 **[SYPT INFANT/LONG TITRATION/]**

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

1 Month [**SYPT SYPC INFANT 1MONTH/]** ☐ 3 Month [**SYPT SYPC INFANT 3MONTH**/] ☐

6 Months [**SYPT SYPC INFANT 6MONTH/]** ☐ 12 Months [**SYPT SYPC INFANT 12MONTH/]** ☐

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.**