

West of Scotland Specialist Virology Centre Request Form

Patient Surname	
Patient Forename	
Patient CHI (or DoB)	___ / ___ / _____
Patient Gender	Male / Female

Ward/Clinic/Laboratory	
Hospital/GP practice/ Laboratory	
Laboratory reference number and address (if laboratory referral)	
Consultant/GP	
Contact Telephone	
Contact Email	
Requestors signature	
Date sample taken	___ / ___ / ___
Time sample taken	___ : ___
Sample type	
Test required	
Suspected diagnosis	
<p>Clinical details</p> <p>Please include:</p> <ul style="list-style-type: none"> *Presenting symptoms/signs *Travel history inc. dates *Known exposures <i>e.g.</i> rash, food, water inc. dates *If pregnant inc. gestation *Bites inc. insect, dates *Known risk factors inc. injecting drugs, sexual, maternal infection 	

FOR LABORATORY USE ONLY					
Spec type	Coded by	Clinical code	COE, B2015,MAD,GJOH,CATCH		
ANTss	HCVAG	B19G	HIVBSE	RS1	
HIVHEPss	HCVG	B19M	RESHIV	RS2	
		CMVG	HIVINT	PCREV	
TXOCss	DBSss	CMVA	HIVR5	PCRBAL	
HIVG	PCRDBS	CMVM	RESHBV	PCREYE	
HIVNDss	HEVG	EBNA	HCVGEN	PCRACE	
HIVGV	HEVM	EBVGA	HCVGS	PJIF	
HIVCON	RUBG	EBVM	HCVRES	MRASHss	
HIVA	SYPH	HSVG	HCVPI	YMRASHss	
HTLVA	ESSss	MEAG	H1H3	PCRTX	
HAVG	SYPHB	MUG	SEQFLA	PCRACE	
HAVM	SYPHM	TOXOGA	SEQFLB	PCRB19	
HAVMV	TPPA	VZVG		PCRHV6	
HBSAG	RPR	HIVSss	PCRSTD	PCRRUM	
HBVCONss		BMTss	PCRNOR	PCRMUM	
HBSAGN	HELSER		PCRGAS	PCRCFS	
HBSAGQ	TBQFG		PCREYE	PCRJC	
HBSAGV			PCRGCC	VRASHss	
HBCG	PCRHIV	PCRMYC	PCRUIPE	PCRHSV	
HBCGV	PCRHAV	PCRASP		PCRGUM	
HBCM	PCRHBV	PCRCF		PCRCT	
HBVEAB	PCRHCW	PCRKBV	DISC	PCRWCV	
HBVEAG	PCRHCV		KEEP 2yr		
HBSAB	PCRHDV			STORE 6m	
	PCRHEV		PERPCR		

