APPENDIX D: STI LAB REQUEST FORM

Specialized STI Testing Request Form, STI Section

Requested by:	
Designation:	
Address:	
Tel:	
Fax:	
Email:	

Patient name:	
Age (sex):	
Date of birth:	
Hospital number:	
Referring laboratory/ hospital:	
Reason/s for referral:	

Laboratory Report

Specimen type:	
Date specimen collected:	
Specimen lab number:	
Test/s requested:	
Date specimen received in STI laboratory:	
STI laboratory number:	
Date specimen tested:	
Assay/s performed:	

Clinical History:

RESULTS:

FINAL RESULT:

Results interpretation:

Results reviewed by: Date:

Results authorised by: Date:

Dr Ranmini Kularatne

MBChB, MSc(Med), DTM&H, Dip HIV Man (SA), PDIC, FCPath(SA) Microbiology

Tel: +27(0)11 555 0465; Fax: +27(0)11 555 0470; Email: ranminik@nicd.ac.za I Website: www.nicd.ac.za