To: NMRU, Jack Copland Centre, SNBTS, 52 Research Avenue North, Heriot Watt Research Park, Edinburgh EH14 4BE

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| If Applicable Attach Barcode Label Here  ………………………………………………… | Serum | For NMRU use only. Affix label here |
| Plasma (PPT) | For NMRU use only. Affix label here. |
| Plasma (EDTA) | For NMRU use only. Affix label here |
| Product | For NMRU use only. Affix label here |

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| **SAMPLE INFORMATION** | | | | | | | | | | | | | | | | | |
| Date of Sample  Withdrawal: |  | | | | | Sample Reference number | | | | | |  | | | | | |
| Sample Types  Sent (): | Serum (dry tube) |  | | Plasma (PPT) | | |  | | Plasma (EDTA) | |  | | | Other | |  | |
| Reason for Referral (): | Repeat  Reactive (RR) |  | Previous RR | |  | | | NAT  Reactive |  | Short Sample | | |  | | Other | |  |
| Additional  Information if applicable | Comment: | | | | | | | | | | | | | | | | |
| Referring  Clinician/Officer |  | | | | | | | | | | | | | | | | |
| Address of referring site: |  | | | | | | | | | | | | | | | | |
| Email address/  Telephone No. |  | | | | | | | | | | | | | | | | |

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| **INVESTIGATION(S) REQUIRED** | | | | | | | | | | |
| FOR CONFIRMATION: | |  | INITIAL SCREEN: | | |  | Please select () | | | |
| Serology  () | HBV |  | HCV |  | HIV |  | HTLV |  | Syphilis |  |
| Anti -HBc |  | Malaria |  | T.Cruzi |  |  | | | |
| NAT () | HBV |  | HCV |  | HIV |  | HEV |  | WNV |  |

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| **TESTING INFORMATION: CONFIRMATORY SAMPLES ONLY** | | | | | | | | |
| Serology | | | | | NAT  (circle as appropriate) | | | |
| Initial  (Index Value) | | Repeat 1  (Index Value) | | Repeat 2  (Index Value) | Reactive | | Non- Reactive | Not applicable |
|  | |  | |  |
| Sent  by: | Print name | | Signature | | | Date: | | |

# INFORMATION TO HELP COMPLETION OF THIS REQUEST FORM:

**This form should be used by Hospital Trusts, Laboratories and Companies, with which the NMRU has a Service Level Agreement in place, that are not part of a blood establishment.**

Send Page 1 only to NMRU with sample(s) for testing. **One form per required investigation only.**

Donor Information: All fields are mandatory.

* Please provide the date of sample withdrawal if applicable.
* Please provide patient ID number/code or product ID number/code
* Provide name of referring clinician or scientific officer. The NMRU report will be sent to this individual.
* Provide address of referring site. The NMRU report will be sent to this address
* Select all sample types being referred to NMRU
* Select why the sample is being referred to the NMRU.

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| Abbreviations: | |
| RR | Repeat Reactive |
| Dry tube | Venous blood, clotted sample. Serum from red top tube |
| PPT | Plasma Preparation Tube. From white top tube |
| EDTA | Plasma form purple top tube |
| NAT | Nucleic Acid Test |
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Investigation Required:

* Select whether for confirmatory testing or an initial screen is required (Mand atory)
* If serology required select marker of infection to be tested (Mandatory)
* If Nucleic Acid Testing (NAT) required select which marker of infection to be tested (Mandatory)
* **One form per required investigation only.**

Testing Information: If confirmatory testing is required provide screen test results (Mandatory). Express serology results as an Index value e.g. OD/COV. Reactive if ≥1.0

If further help is required to complete this form see contact details below: Contact Telephone number: 0141 433 5923

Contact email address: [NSS.SNBTS-NMRUSeniorStaff@nhs.net](mailto:NSS.SNBTS-NMRUSeniorStaff@nhs.net)