

Laboratory Number

Date Collected (dd/mm/yy) * _____ * Time Collected (hr/min) _____

Routine Urgent

Sender's Referral Number

N / A _____

Specimen Type

B L O O D _____

For Name(s)

Date of Birth (dd/mm/yy)

NHS Number

order

Female Male

District Number N / A _____

Hospital / Reference Number

N / A _____

N/A Private

Address

N / A _____

Town

N / A _____

Post Code

N / A _____

Consultant / GP

Ward / Department / Surgery /

Location / Hospital

Location = MAHUS

Address

Clinical Features

KEEP WRITING WITHIN THE BOX LINES. FILL BOXES LIKE THIS FILL BOXES LIKE THIS

Immunocompromised (Give details)

Solitis Therapy: YES NO

Ravulizumab (Ultomiris) YES NO

Post Vaccination (Give details)

Other (Give details)

Serological Tests (7 mls diluted blood) FILL BOXES LIKE THIS

- _____
- _____
- _____
- Meningococcal serogroup C bactericidal
- Meningococcal serogroup Y bactericidal
- Meningococcal serogroup W bactericidal
- _____
- _____
- _____

THIS FORM MUST ACCOMPANY THE SAMPLE TO ENSURE THE COST IS COVERED BY THE NATIONAL aHUS SERVICE ONLY TO BE USED FOR PATIENTS OF NATIONAL aHUS SERVICE



DEPARTMENT OF VIROLOGY
Manchester Medical Microbiology Partnership

Postal Address
PO Box 209
Clinical Sciences Building
Manchester Royal Infirmary
Oxford Road
Manchester M13 9WL

HayesDX Address
Medical Microbiology Partnership
DX6962410
Manchester 90M

Call Centre Telephone Numbers
0161 276 8854/8788
Fax Numbers
0161 276 5744/8787

SPECIMEN ACCEPTANCE POLICY

Guidance for Pathology Laboratories, CsCDC and Local Authorities
Specimens must be correctly labelled and request forms adequately completed.

PLEASE FOLLOW THE RULES

Specimens MUST be labelled with the following:-

Surname

PLUS any two out of three of:-

- Forename
- Full date of Birth
- NHS Number

AKD Date of Collection of Specimen

Specimens from Sexual Health Clinics MUST be labelled with the following:-
ID Number
Full Date of Birth

Request forms MUST match the information on the sample

PLUS

- Address for the Report
- Consultant, GP or CsCDC
- Name of Requester
- Tests Required

Request forms SHOULD have

- Time and Date
- Gender
- Sender's Reference / Laboratory Number
- Contact Number for Requester
- Relevant Clinical Information
- Post Code
- ILOG Number (for outbreaks and studies)