



# REQUISITION FOR SYPHILIS REFERENCE TESTING

## Syphilis Diagnostics and Vaccine Preventable Bacterial Diseases

National Microbiology Laboratory  
1015 Arlington Street, Winnipeg, MB R3E 3R2  
Telephone: (204) 789-2130 Fax: (204) 789-2018

### SENDER INFORMATION

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

PROVINCE: \_\_\_\_\_

POSTAL CODE: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

### PATIENT INFORMATION

PATIENT INITIALS: \_\_\_\_\_

DATE OF BIRTH (YYYY-MM-DD): \_\_\_\_\_

SEX             M         F

CITY: \_\_\_\_\_

OTHER INFORMATION:

### SPECIMEN INFORMATION

SPECIMEN REF #: \_\_\_\_\_

COLLECTION DATE (YYYY-MM-DD): \_\_\_\_\_

DATE OF DISEASE ONSET (YYYY-MM-DD): \_\_\_\_\_

SERUM     CSF         WHOLE BLOOD

SWAB (SOURCE): \_\_\_\_\_

OTHER (SPECIFY): \_\_\_\_\_

### TEST REQUIRED

Select all that apply:

- |                                  |                                  |   |
|----------------------------------|----------------------------------|---|
| SEROLOGY                         | CSF SEROLOGY                     | MOLECULAR TESTING                                       |
| <input type="checkbox"/> RPR     | <input type="checkbox"/> VDRL    | <input type="checkbox"/> PCR DETECTION                  |
| <input type="checkbox"/> VDRL    | <input type="checkbox"/> FTA-ABS | <input type="checkbox"/> AZITHROMYCIN<br>SUSCEPTIBILITY |
| <input type="checkbox"/> FTA-ABS |                                  |   |
| <input type="checkbox"/> TP-PA   |                                  |   |
| <input type="checkbox"/> EIA     |                                  |   |

### CLINICAL HISTORY

PREVIOUS LAB RESULTS:

TRAVEL HISTORY:

### COMMENTS