SALMONELLA, *SHIGELLA* & *LISTERIA* REQUEST FORM, GALWAY REFERENCE LABORATORY, DEPARTMENT OF MEDICAL MICROBIOLOGY, GUH, GALWAY

Laboratory Use Only

Senders Information

***Referring Laboratory name, postal address and contact Number:** (for laboratory issues) **Hospital/Healthcare Facility** *(if different from sender)*	* **Person to whom result should be addressed (Consultant or person delegated to receive the result) Name, Contact Number and email:**
***Sender's Reference Number:**	* **Primary Sample Date:**
***Isolate Details:** Salmonella ☐ Shigella ☐ Listeria☐ **Identification Method:**	**Isolation Date** (optional)

Isolate Information

* **If you suspect the specimen requires handling at CL 3 please tick**

☐ **? *S.* Typhi** ☐ **? *S.* Paratyphi** ☐ **? *Shigella dysenteriae***

Senders Lab Findings:

***Travel Outside of Ireland in the 4 weeks before onset of illness (Mandatory Field, sample may be rejected if this is not filled)**

Yes ☐ **No**☐ **Not known** ☐

If "Yes" please state the country if known

If further travel history/clinical details become available please email christina.clarke@hse.ie or phone 091-544628

* **Isolate Source:** ☐**Faeces** ☐**Blood** ☐**CSF** ☐ **Other (please specify)**

Clinical/ Epidemiological information if available:

☐ **Relevant animal contact (please specify)**
☐ **Outbreak Associated(please specify and provide an outbreak code)**
☐ **Suspected transmission mode, e.g. implicated food, person-to-person**
☐ **Suspected healthcare associated**

Patient Details

* **Surname:**	* **First Name:**
* **D.O.B:**	* **Sex:** **M** ☐ **F**☐ **Other**☐
Patient address:	

* All these fields are compulsory to comply with minimum laboratory requirements