National Virus Reference Laboratory
University College Dublin
Belfield, Dublin 4

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SARS CoV-2 REQUEST FORM

PATIENT DETAILS

Forename:

Surname:

Address:

DOB: D D M M Y Y Y Y

Sex : F M

NB: Please note that both the sample(s) and the test request form must detail the patients name and DOB

SPECIMEN DETAILS

Specimen Type(s): *Nasopharyngeal swab AND/OR Oropharyngeal swab*

Specimen Date & Time of collection: D D M M Y Y Y Y

H H M M

CLINICAL DETAILS

Clinical details aid the selection of an optimal testing strategy. Please include duration of illness and relevant vaccination/travel history

Clinical Details

Date of onset of symptoms: D D M M Y Y Y Y

TRAVEL HISTORY

TRAVEL HISTORY (within previous 14 days):

_____

_____

Contact History:

_____

_____

Date Returned: _____

REQUESTING AMBULANCE DETAILS

Name:

Signature:

D D M M Y Y Y Y

Date:

Tel:

Contact name and number of person result is to be phoned to: _____

Department of Health

Please tick the appropriate box

Eastern Health Board (EHB).....□
Midland Health Board (MHB).....□
Mid-Eestern Health Board (MWHB).....□
North-Western Health Board (NWHB).....□
Noth-Eastern Health Board (NEHB).....□
South Eastern Health Board (SEHB).....□
Southern Health Board (SHB).....□
Western Health Board (WHB).....□

NAS Incident Number: _____