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NHS Highland

Toxoplasma request form

(Please complete as fully as possible. A minimum of three forms of identification required)

Patient information

Surname:	DOB/CHI:	
Forename:	Male ☐	Female ☐
Address/Postcode:		

Sample information

Sender's Ref No.:
Date collected:
Screening test results (if any):

Sample type:

- ☐ Serum (500µl)
- ☐ Plasma (500µl)
- ☐ CSF (200µl)
- ☐ Tissue (25mg)
- ☐ Whole blood (1ml)
- ☐ Other (please state below):

Other:

Clinical information

Date of onset of signs/ symptoms:
Contact with cats?
Contact with farm livestock?
Consumption of unpasteurised milk/dairy product?
Consumption of undercooked/raw meat?
Other contact/sources of infection:

Signs/symptoms:

- ☐ Lymphadenopathy
- ☐ Ocular
- ☐ Pregnant
- ☐ Congenital
- ☐ BMT transplant
- ☐ Organ transplant
- ☐ HIV
- ☐ Neurological
- ☐ Other (please state below):

Other:

Sender's information

Sender's name and address:	Additional details/clinical information: