Royal Centers for Disease Control

Ministry of Health

SYPHILIS LABORATORY TEST REQUEST FORM

Name of the Health facility:			
Patient Information			
Name: Age/Sex:			
CID:			
Laboratory Information			
Sample ID:			
Date of collection: Date of shipment:			
Test Kit(s) used:	Lot No.:	Expiry date:	Test result:
1. TPPA_____	1._____	1._____	1._____
2. RPR _____	2._____	2._____	2._____
Tested by (Name and signature): Test date:			
Name, designation, contact add of the person to be notified:			
This section is to be Filled by RCDC Only			
Received by: Date:			
Sample condition: Good: Not good, specify:_____			
New sample ID:			
Test kit(s) used:	Lot No.:	Expiry date:	
1._____ 2._____ 3._____	1._____ 2._____ 3._____	1._____ 2._____ 3._____	
Analyzed by (Name and signature): Test date:			
Notified to:			
Notified by: Date:			

Note: Samples should be shipped frozen or at 2-8°C