



CPA Accredited

Varicella Zoster Reference Service,
Department of Virology
3rd Floor 51-53 Bartholomew Close
West Smithfield
London EC1A 7BE

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BARBICAN 90EC

**Varicella Zoster Virus Serology
For Vaccine and Non- Vaccine
Associated Clinical Symptoms**

Specialist & Reference
Microbiology Division.

SBAR06

Requestor Address

Telephone Number

Senders Reference Number.

A. Patient Information

SURNAME

FORENAME

NHS Number

Hospital Number

Male Female

Pregnant Gestation x/40 Date of Birth Hospital

Sample Type Vesicle Fluid Saliva C.S.F Plasma DNA Scab Viral Isolate Serum Other

Date of sample

If this is a vaccine related problem please fill in B. Otherwise go straight to C.

B. Vaccine related samples - please fill in 1,2,3 and/or 4 if relevant

1. Pre Vaccination serology required? Yes No

2. Post Vaccination serology required? Yes No

3. Oka Vaccine 1st dose Please tick Manufacturer GSK MERCK Batch/Lot No Date of Administration

4. Oka Vaccine 2nd dose Please tick Manufacturer GSK MERCK Batch/Lot No Date of Administration

Nature of vaccine related problem (please tick one and give more details in C) Vaccine rash (<42 days post immunization) Breakthrough varicella rash (>42 days post immunization) Herpes zoster in a vaccinee

Failure to seroconvert post vaccination Other complication

Nature of rash (if present) At vaccine inoculation site Localised away from vaccine inoculation site Generalised

Other (please give details)

Date of onset

C. Clinical Information: If not vaccine related please give full clinical details including, if relevant, nature of exposure to V.Z.V and date, immunodeficiency status, nature of clinical problem and precise test required if known

Requesting Doctor