**SAMPLE DETAILS**

**Before handing in your sample please ensure all details are filled in on the container: name, date of birth, date and time of sample.**

**Patient name**: …………………………………..…………………………………….. **Patient date of birth:** ……………………………………

**Reason for sample (please tick below): Telephone number: ………………………………….….**

 **The Doctor/Nurse asked for the sample**

 **I think I have an infection (please indicate symptoms below):**

 Dysuria (painful or difficult urination) Frequency

 Suprapubic/lower abdominal pain Urgency

Polyuria (abnormally large volumes) Haematuria (blood)

**Do you have any vaginal discharge? YES / NO Do you have vaginal itching? YES / NO**

**For how long have you had these symptoms …………………………………………………..**

**Other Information ………………………………………………………………………………………...................................................**

**I have / have not already finished a course of antibiotics (delete as appropriate)**

Symptoms relieved Still symptomatic

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