



Food Hygiene Laboratory
 Environmental Microbiological Unit
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FOOD HYGIENE LABORATORY REQUEST FORM



Corporate Accreditation No. 2392
 NATA Accreditation No. 2851

Company Name: Address: Contact Name: Contact Phone: Contact Email: Date Sampled: Sampled by: Purchase Order Number: Signed:	Purpose of Analysis (please tick) <input type="checkbox"/> Food Complaint (please complete back of the form) <input type="checkbox"/> Food Poisoning (please complete back of the form) <input type="checkbox"/> Routine Monitoring: Total Plate count, <i>E. coli</i> count and Coagulase Positive Staph count. <i>L. monocytogenes</i> and <i>Salmonella spp</i> detection. Or Select Tests <input type="checkbox"/> Total Plate count <input type="checkbox"/> <i>E.coli</i> count <input type="checkbox"/> Coag Pos Staph count <input type="checkbox"/> <i>L. monocytogenes</i> <input type="checkbox"/> <i>Salmonella spp</i> <input type="checkbox"/> <i>Bacillus cereus</i> <input type="checkbox"/> <i>Clostridium perfringens</i> <input type="checkbox"/> <i>Campylobacter spp</i> <input type="checkbox"/> <i>Vibrio spp</i> <input type="checkbox"/> Yeast and Mould <input type="checkbox"/> Coliform count Other Tests _____	Additional Sample Comments: Survey Code
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Laboratory Use Only	Client's Reference Number	Food Type (include lot numbers)	Brand	Date of Manufacture	Use by Date	Temp (°C)

Delivery Method Courier Client O/N Trolley Other	By:	Temperature	Report Type: Authorised By: Date:	Emailed:
Date and Time Received:				

FOOD COMPLAINT / POISONING INCIDENT REPORT

Did the complainant consume the sample submitted?

YES

NO

Number of persons affected:

Date/time food consumed:

Number of persons at risk:

Date/time onset of illness:

Symptoms:

Diarrhoea

Stomach cramps

Rash

Fever

Vomiting

Other (specify):

All foods consumed 48 hours prior to onset:

Additional sender's comments: