SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

MICROBIOLOGY LABORATORY
555 University Avenue
Room 3676, Atrium
Toronto, ON, M5G 1X8, Canada
Tel: 416-813-7200
Fax: 416-813-6599

MOLECULAR MICROBIOLOGY

Referred-in SEROLOGY Requisition

Last Name:

First Name:

Date of Birth (DD/MM/YYYY):

Gender: ☐ *Male* ☐ *Female*

For Canada Only

Provincial Health Card #: *Version:*

Issuing Province:

IF NOT SICKKIDS PATIENT SEND REPORT TO:

Referring Physician Full Name:

_____
(Last Name, First Name)

Mailing Address:

Referring Laboratory: _____

Telephone Number: _____

Referring Lab Accession #: _____

Fax Number: _____

SHIPPING INSTRUCTIONS:

All specimens that DO NOT MEET the transport requirements will be **REJECTED**.

ANTI-NMDAR antibodies

- **Specimens can be stored at 4°C for up to 14 days or frozen specimens may be shipped on wet or dry ice.**

ALL OTHER SPECIMENS

- **All specimens MUST** be shipped ON DRY ICE.
  - **Exception:** Specimens that will arrive at SickKids within 24 hours from the time of collection can be shipped ON ICE PACKS.

SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

MICROBIOLOGY LABORATORY
555 University Avenue
Room 3676, Atrium
Toronto, ON, M5G 1X8, Canada
Tel: 416-813-7200
Fax: 416-813-6599

Last Name:

First Name:

Date of Birth (DD/MM/YYYY):

Gender: ☐ *Male* ☐ *Female*

Referring Lab Accession #:

MOLECULAR MICROBIOLOGY

Referred-in SEROLOGY Requisition

SPECIMEN COLLECTION INFORMATION	
Date (DD/MM/YYYY)	**Time** (HH:MM)

SPECIMEN AMOUNT	**Clotted blood**: 1mL for 1 test; 6mL for multiple serology tests

	TESTS	▲RECOMMENDED SPECIMEN • TESTING SCHEDULE
☐	**Anti-NMDAR** (N-Methyl-D-aspartate-receptor) antibodies	**▲CSF 0.5mL minimum,** ☐ **▲Serum 0.5mL,** ☐ **▲Clotted blood (Red Top),** ☐ • x1 per week, dictated by demand
☐	**ASOT**	**▲Clotted blood (Red Top),** • Weekly
☐	**CMV IgG**	**▲Clotted blood (Red Top),** • x2 per week
☐	**EBV Serology (VCA/EA/EBNA)**	**▲Clotted blood (Red Top),** • Weekly
☐	**HSV IgG**	**▲Clotted blood (Red Top),** • Weekly
☐	**Monospot**	**▲Clotted blood (Red Top),** • Daily
☐	**Mycoplasma IgM**	**▲Clotted blood (Red Top),** • x2 per month
☐	**VZV IgG**	**▲Clotted blood (Red Top),** • x2 per month
☐	**Other, specify** _____	**Please indicate if:** Acute ☐ Convalescent ☐

SickKids®
THE HOSPITAL FOR SICK CHILDREN
Paediatric Laboratory Medicine

MICROBIOLOGY LABORATORY
555 University Avenue
Room 3676, Atrium
Toronto, ON, M5G 1X8, Canada
Tel: 416-813-7200
Fax: 416-813-6599

Last Name:

First Name:

Date of Birth (DD/MM/YYYY):

Gender: ☐ *Male* ☐ *Female*

Referring Lab Accession #:

MOLECULAR MICROBIOLOGY

Referred-in SEROLOGY Requisition

BILLING FORM

How to complete the Billing Form: *(Completion of Billing Form NOT required for patients with an Ontario Health Card Number.)*

- **Referring Physician completes the appropriate section below to specify billing method.**
- **Send requisition and completed "Billing Form" with specimen.**

Option 1: Complete to have the Healthcare Provider billed:

Your Referring Laboratory's Reference #: _____

Billing address of hospital, referring laboratory:

Name:_____

Address: _____

City:_____Prov/State: _____

Postal/Zip Code: _____ Country: _____

Contact Name: _____

Contact Telephone #: _____

Option 2: Interm Federal Health Program (IFHP)

Submit a copy of the Interim Federal Health Certificate (Refugee Protection Claimant Document) with the photo and UCI# visible for coverage to be confirmed.

UCI# _____

ICD code *(lab use only)*:_____

Option 3: Complete to have Patient/Guardian billed directly:

If you elect to have patient/guardian billed:

- *Patient/Guardian billing information below must be complete; otherwise, the healthcare provider will be billed.*
- *Please advise the patient/guardian to expect a bill from our laboratory.*
- ***In this case, the patient/guardian is solely responsible for the charges.***

Relation to patient (check one): ☐ Patient ☐ Guardian/Parent

Method of Payment (check one): ☐ American Express ☐ MasterCard ☐ Visa

Name as it appears on credit card: _____

Credit card # : _____

Expiry date on credit card: _____

CVC#- found on back of card (Required): _____

Mailing Address of Patient/Guardian (if different from requisition):

Name: _____

Address: _____

_____ Apt. #: _____

City: _____ Prov/State: _____

Postal/Zip Code: _____ Country: _____

Additional Contact Information

Patient's phone # with area code:

_____

- or -

Guardian's phone # with area code:

_____