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

Cell Line Type:

Your Reference Lab #:

MOLECULAR MICROBIOLOGY

Mycoplasma Cell Line Testing

SPECIMEN COLLECTION INFORMATION

Date (DD/MM/YYYY)	**Time** (HH:MM)

Testing intended for cell lines used in bench research ONLY, NOT for clinical use in patients.

Client Name _____ *Tel #* _____
(Last Name, First Name)

Complete Mailing Address

Institution _____

Laboratory/Department _____ Room # _____

Street Address _____

City _____ Province _____ Postal Code _____

Alternate Contact _____ *Tel #* _____

Preparation of Cell Lines for Microbiology Testing

- When cells have **not been treated** with antibiotics, they must be in the second passage.
- When cells have **been treated** with antibiotics, they must be passaged at least six (6) times in antibiotic free medium.
- For a monolayer, cell confluence must be over 80%. Suspend in 5mL of growth media (antibiotic free).
- For a suspension, cell count should be greater than 10^6 cell per mL.

Submission of Samples to Microbiology Laboratory

- Send 2 aliquots of cells, 200 to 300 uL for each, in 1.5mL microfuge tubes.
  Cells in T25 flask will be rejected.
- Ice pack accepted if travel time to laboratory ≤ 24 hours.
- Recommended sending frozen if travel time ≥ 24 hours.

Receipt of Samples

- Testing is performed once weekly. Samples **must be received** in the Microbiology Laboratory, Room 3676, 3rd Floor Atrium, SickKids no later than 0930h Monday morning to be included in the week testing.
- When the Monday is a statutory holiday, samples submitted **no later than 0930h Tuesday morning** will be accepted for the week testing.

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

Cell Line Type:

Your Reference Lab #:

MOLECULAR MICROBIOLOGY

Mycoplasma Cell Line Testing

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

Please indicate payment method

Invoices are issued upon completion of test/service provided. At your direction, we will invoice the referring hospital, referring laboratory, referring physician, or research fund, for the services we render.

- ☐ **Apply charges to Fund/Study #:** _____
- ☐ **Apply charges to credit card (complete section below)**

Complete to have charges applied to a credit card

If you elect to have a charge applied to a credit card:

- *Charge card information must be complete; otherwise, referring client will be invoiced.*

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

Name as it appears on credit card: _____

Credit card #: _____

Expiry date on credit card: _____

LABORATORY USE ONLY

Client Code / Account #: _____

Specimen / Accession #: _____

Cell Line Type: _____