

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

For Canada Only

Provincial Health Card #:

Version:

Issuing Province:

MOLECULAR MICROBIOLOGY

Referred-in VIRAL Requisition

IF NOT SICKKIDS PATIENT SEND REPORT TO:

Referring Physician Full Name:

Mailing Address:

(Last Name, First Name)

Referring Laboratory: _____

Telephone Number: _____

Referring Lab Accession #: _____

Fax Number: _____

SHIPPING INSTRUCTIONS

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

Specimens that will arrive at SickKids within 5 days from the time of collection can be shipped ON ICE PACKS.

If **> (greater than) 5 days** from the time of collection, specimens **MUST** be shipped **FROZEN ON DRY ICE**.

TEST REQUESTED

Please indicate below test(s) required. * Consult a Microbiologist for testing outside the Testing Schedule.

* Page Microbiologist on-call through locating 416-813-1500 **PRIOR TO SENDING SPECIMENS**

Specimen Volume:

- **Bone Marrow (EDTA)** - 1 mL minimum for 1 test, 3-5 mL recommended for multiple tests
- **CSF** - 200-300 ul per 1 test, **for multiple tests please ensure adequate sample volume is submitted.**
- **Serum or Plasma** - 0.5 mL minimum for 1 test, >1 mL recommended for multiple tests.
- **Stool** - Cary-Blair transport medium or in sterile container, **NOT** in container with preservative.
- **Whole Blood (EDTA)** - 1 mL minimum for 1 test, 3-5 mL recommended for multiple tests.
- **Urine** - 1 mL minimum for 1 test, 2-3 mL recommended for multiple tests.

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SPECIMEN COLLECTION INFORMATION

Date (DD/MM/YYYY)

Time (HH:MM)

SPECIMEN TYPE

RELEVANT DIAGNOSIS

TESTS

▲ RECOMMENDED SPECIMENS • TESTING SCHEDULE

<input type="checkbox"/>	Adenovirus QUALitative PCR	▲ Urine • Lower respiratory specimens • CSF • 5x per week
<input type="checkbox"/>	Adenovirus QUANTitative PCR	▲ Plasma • 5x per week
<input type="checkbox"/>	BK virus QUANTitative PCR	▲ Plasma • Urine • 5x per week
<input type="checkbox"/>	JC Virus QUALitative PCR	▲ CSF • Tissue • Dictated by demand
<input type="checkbox"/>	CMV QUALitative PCR	▲ Urine • CSF in suspected congenital CMV • 2x per week
<input type="checkbox"/>	CMV QUANTitative PCR	▲ Whole Blood (EDTA) • 2x per week
<input type="checkbox"/>	Enterovirus RT-PCR	▲ CSF • Whole Blood (EDTA) • Lesion scraping • Tissue • 5x per week
<input type="checkbox"/>	Parechovirus RT-PCR <i>Limited to children ≤ 1 year of age</i>	▲ CSF • Dictated by demand
<input type="checkbox"/>	EBV - QUANTitative PCR	▲ Whole Blood (EDTA) • 2x per week
<input type="checkbox"/>	Gastrointestinal Pathogen Multiplex PCR VIRUSES: Adenovirus 40/41, Rotavirus, Norovirus BACTERIA: <i>Salmonella</i> spp., <i>Shigella</i> spp., <i>Yersinia enterocolitica</i> , <i>Campylobacter jejuni/coli/lari</i> , <i>Clostridium difficile</i> toxin A/B, Enterotoxigenic <i>E.coli</i> (ETEC), <i>E.coli</i> 0157, Shiga-toxin producing <i>E.coli</i> (STEC or EHEC).	▲ Stool • Ileostomy Fluid • 6x per week <input type="checkbox"/> <i>C. difficile</i> EIA reflex testing for GDH/tox A & B - available if PCR positive. Check box if you wish this testing to be performed
<input type="checkbox"/>	HSV-1, HSV-2, VZV PCR	▲ CSF • Other Sterile Body Fluids • Lesion scraping • Whole Blood (EDTA) • Other • Daily on CSF/SBF specimens received by 8:30am • Next day for Lesions received by 1:00pm
<input type="checkbox"/>	CMV, EBV, HHV-6, PCR <input type="checkbox"/> Add HHV-7 PCR	▲ Whole Blood (EDTA) • Tissue • Other • Daily on specimens received by 10:00am
<input type="checkbox"/>	Herpes virus 8 PCR (HHV-8)	▲ Tissue • Lesion scraping • Dictated by demand
<input type="checkbox"/>	Parvovirus B19 PCR	▲ Plasma • Serum • Bone Marrow • Amniotic Fluid • Tissue (placenta, cardiac) • 2x per week
<input type="checkbox"/>	Respiratory Virus Multiplex PCR <i>(Influenza A/B, RSV A/B, Adenovirus, Human metapneumovirus, Coronavirus, Parainfluenza virus 1/2/3/4, Rhinovirus A/B/C, Enterovirus, Bocavirus)</i>	▲ Lower respiratory specimens • Nasopharyngeal Swab • 5x per week
<input type="checkbox"/>	West Nile virus and other mosquito borne Flaviviruses <i>Includes Dengue, Japanese Encephalitis, St. Louis Encephalitis</i>	▲ Plasma • Serum • CSF • Dictated by demand (May to November)



**THE HOSPITAL FOR
SICK CHILDREN**

**Paediatric
Laboratory Medicine**

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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: _____
