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):
Legal Sex: ○ *Male* ○ *Female* ○ *Non-binary/U/X*
Sex Assigned at Birth (if different): ○ *Male* ○ *Female* ○ *Unassigned*
Gender Identity: ○ *Male* ○ *Female* ○ *Non-binary/U/X*
For Canada Only
Provincial Health Card #: *Version:*
Issuing Province:

MOLECULAR MICROBIOLOGY

Referred-in FUNGAL Requisition

Testing is provided for medical purposes only and results are not intended for forensic use. The laboratory is not a forensically accredited laboratory.

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**.

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**.

Exception: Slides and blocks for Fungal PCR (room temperature)

TEST REQUESTED

Please indicate below test(s) required. * Consult a Microbiologist for testing outside the Testing Schedule.
If Formalin-fixed paraffin-embedded (FPE) biopsy with no organisms seen on smear, 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**.
- **Whole Blood (EDTA)** - 1 mL minimum for 1 test, 3-5 mL recommended for multiple tests.
- **Formalin**-fixed paraffin-embedded (FPE) biopsy
- **Fresh biopsy**

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SPECIMEN COLLECTION INFORMATION

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

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SPECIMEN TYPE	RELEVANT DIAGNOSIS

TESTS NEXT GENERATION SEQUENCING (NGS)		▲ RECOMMENDED SPECIMENS
☐	**Fungal detection through targeted NGS** (only fungal stain positive GMS or calcofluor) specimens will be processed. **Specimens without accompanying fungal stain results will be rejected.)**	▲ **Tissue block (formalin fixed):** ■ Must send slides (H&E, GMS, PAS) and copy of Pathology report ▲ **Fresh tissue or fluid** ■ Must send copy of report with fungal stain results

TESTS PATHOGEN SPECIFIC PCR		▲ RECOMMENDED SPECIMENS
☐	**Aspergillus PCR** ☐ Aspergillus flavus / fumigatus PCR ☐ Aspergillus terreus / niger PCR	▲ **BAL** ● *Dictated by demand*
☐	***Pneumocystis jirovecii* PCR**	▲ **BAL** ● *Dictated by demand*

PATIENTS CLINICAL INFORMATION:

1.	Patient is on antifungal therapy	☐Yes	☐No
2.	Imaging suggestive of invasive Fungal Infection	☐Yes	☐No
3.	Hematopoietic stem cell transplant (HSCT)	☐Yes	☐No
4.	Solid organ transplant (SOT)	☐Yes	☐No
5.	Congenital Immunodeficiency	☐Yes	☐No
6.	On immunomodulating agents	☐Yes	☐No
7.	Other immunocompromising condition (please specify):	☐Yes	☐No

_____

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

SPECIMEN TYPE	RELEVANT DIAGNOSIS

BILLING FORM

The hospital, referring laboratory, or a patient/guardian will be billed for the services rendered.

- Invoices are sent upon completion of each test/service.
- Contact SickKids' Laboratory at 416-813-7200 with billing inquiries.

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.*
- *Provide us with patient's valid credit card information.*
- *Unfortunately, we cannot accept personal checks.*
- ***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): _____