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 VIRAL 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**.

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) _________

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SPECIMEN TYPE	RELEVANT DIAGNOSIS

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

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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:
____