

**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: \_\_\_\_\_  
**Cell Line Type:** \_\_\_\_\_  
**Your Reference Lab #:** \_\_\_\_\_

**MOLECULAR MICROBIOLOGY**

***Mycoplasma* Cell Line Testing**

**SPECIMEN COLLECTION INFORMATION**

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

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

**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<sup>6</sup> 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.

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**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:** \_\_\_\_\_