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 BACTERIAL 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 48 hours from the time of collection can be shipped ON ICE PACKS.

If **> (greater than) 48 hours** 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 NEXT GENERATION SEQUENCING (NGS)	▲ RECOMMENDED SPECIMENS
○	**Direct 16S PCR**	▲ **CSF • Body Fluid (Joints/Synovial, Pleural, Pericardial, Peritoneal)**

	TESTS PATHOGEN SPECIFIC PCR	▲ RECOMMENDED SPECIMENS
○	***Bordetella pertussis* PCR**	▲ **Nasopharyngeal swab, throat swab, sputum, BAL**
○	***Bartonella* group PCR** *(B. henselae, B. quintana, B. bacilliformis, B. clarridgeiae, B. elizabethae and B. vinsonii subsp. berkhoffii)*	▲ **Lymph node biopsy/aspirate • Whole Blood in EDTA (possible endocarditis)**
○	***B. cepacia* complex Genomovar Typing**	▲ **Bacterial isolate on charcoal transport swab**
○	**Gastrointestinal Pathogen Multiplex PCR** **VIRUSES**: Adenovirus 40/41, Rotavirus, Norovirus **BACTERIA:** *Salmonella* spp., *Shigella* spp., *Yersinia enterocolitica*, *Campylobacter jejuni/coli/lari*, *C.difficile* toxin A/B, Enterotoxigenic *E.coli* (ETEC), *E.coli* 0157, Shiga-toxin producing *E.coli* (STEC or EHEC).	▲ **Stool • Ileostomy Fluid** *C. difficile EIA will be performed if C. difficile PCR positive.*
○	***Kingella kingae* PCR** *Recommended for children ≤ 6 years old*	▲ **Joint/Synovial Fluid • Bone Biopsy • Heart valve vegetation**
○	***Mycoplasma/Chlamydophila pneumoniae* PCR**	▲ **Throat swab • BAL • CSF• Nasopharyngeal swab**

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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): _____