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: 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 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	▲ SPECIMEN REQUIREMENTS
☐	**Adenovirus QUALitative PCR**	**▲Urine • CSF • Stool • Eye Swab • Eye Fluid • Corneal Scraping • Biopsy**
☐	**Adenovirus QUANtitative PCR**	**▲Plasma**
☐	**BK virus QUANtitative PCR**	**▲Plasma • Urine**
☐	**JC Virus QUALitative PCR**	**▲CSF • Brain Biopsy**
☐	**Cytomegalovirus (CMV) QUALitative PCR**	**▲Urine**
☐	**Cytomegalovirus (CMV) QUANtitative PCR**	**▲Whole Blood (EDTA) • plasma**
☐	**Enterovirus RT-PCR**	**▲CSF • plasma**
☐	**Parechovirus RT-PCR** *Limited to children ≤ 1 year of age*	**▲CSF**
☐	**Epstein Barr virus (EBV) - QUANtitative PCR**	**▲Whole Blood (EDTA) • plasma**
☐	**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 is positive.*
☐	**Herpes simplex Virus 1 (HSV-1), Herpes Simplex Virus 2 (HSV-2), Varicella Zoster Virus (VZV) PCR**	**▲CSF • Sterile Body Fluids • Eye Swab • Eye Fluid • Corneal Scraping • Oral Swab • Lesion Scraping • Whole Blood (EDTA)**
☐	**Cytomegalovirus (CMV), Epstein Barr Virus (EBV), Human Herpes Virus 6 (HHV-6), PCR**	**▲Whole Blood (EDTA) • CSF • BAL • Eye Fluid • Sterile Body Fluid • Biopsy**
☐	**Human Herpes virus 7 (HHV-7) PCR**	**▲ Whole Blood (EDTA) • CSF**
☐	**Human Herpes virus 8 (HHV-8) PCR**	**▲Tissue • Lesion scraping • Whole Blood (EDTA)**
☐	**Parvovirus B19 PCR**	**▲Plasma • Serum • Bone Marrow • Amniotic Fluid • Tissue (placenta, cardiac)**
☐	**Respiratory Virus Multiplex PCR** *(Influenza A/B, Respiratory syncytial virus (RSV), SARS-CoV-2, Adenovirus, Human metapneumovirus, Coronavirus, Parainfluenza virus 1/2/3/4, Rhinovirus A/B/C, Enterovirus, Bocavirus)*	**▲BAL • Lung Biopsy • Nasopharyngeal Swab**
☐	**West Nile virus** and other **mosquito borne Flaviviruses** *Includes Dengue, Japanese Encephalitis, St. Louis Encephalitis*	**▲Plasma • Serum • CSF**

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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:

_____