



**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
<b>TESTS</b>		<b>▲ SPECIMEN REQUIREMENTS</b>
<input type="checkbox"/>	Adenovirus QUALitative PCR	▲ Urine • CSF • Stool • Eye Swab • Eye Fluid • Corneal Scraping • Biopsy
<input type="checkbox"/>	Adenovirus QUANTitative PCR	▲ Plasma
<input type="checkbox"/>	BK virus QUANTitative PCR	▲ Plasma • Urine
<input type="checkbox"/>	JC Virus QUALitative PCR	▲ CSF • Brain Biopsy
<input type="checkbox"/>	Cytomegalovirus (CMV) QUALitative PCR	▲ Urine
<input type="checkbox"/>	Cytomegalovirus (CMV) QUANTitative PCR	▲ Whole Blood (EDTA) • plasma
<input type="checkbox"/>	Enterovirus RT-PCR	▲ CSF • plasma
<input type="checkbox"/>	Parechovirus RT-PCR <i>Limited to children ≤ 1 year of age</i>	▲ CSF
<input type="checkbox"/>	Epstein Barr virus (EBV) - QUANTitative PCR	▲ Whole Blood (EDTA) • plasma
<input type="checkbox"/>	<b>Gastrointestinal Pathogen Multiplex PCR</b> VIRUSES: Adenovirus 40/41, Rotavirus, Norovirus BACTERIA: <i>Salmonella</i> spp., <i>Shigella</i> spp., <i>Yersinia enterocolitica</i> , <i>Campylobacter jejuni/coli/lari</i> , <i>C.difficile</i> toxin A/B, Enterotoxigenic <i>E.coli</i> (ETEC), <i>E.coli</i> 0157, Shiga-toxin producing <i>E.coli</i> (STEC or EHEC).	▲ Stool • Ileostomy Fluid <i>C. difficile</i> EIA will be performed if <i>C. difficile</i> PCR is positive.
<input type="checkbox"/>	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)
<input type="checkbox"/>	Cytomegalovirus (CMV), Epstein Barr Virus (EBV), Human Herpes Virus 6 (HHV-6), PCR	▲ Whole Blood (EDTA) • CSF • BAL • Eye Fluid • Sterile Body Fluid • Biopsy
<input type="checkbox"/>	Human Herpes virus 7 (HHV-7) PCR	▲ Whole Blood (EDTA) • CSF
<input type="checkbox"/>	Human Herpes virus 8 (HHV-8) PCR	▲ Tissue • Lesion scraping • Whole Blood (EDTA)
<input type="checkbox"/>	Parvovirus B19 PCR	▲ Plasma • Serum • Bone Marrow • Amniotic Fluid • Tissue (placenta, cardiac)
<input type="checkbox"/>	<b>Respiratory Virus Multiplex PCR</b> <i>(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)</i>	▲ BAL • Lung Biopsy • Nasopharyngeal Swab



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**SPECIMEN TYPE**

**RELEVANT DIAGNOSIS**

**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:**

**Option 2: Interm Federal Health Program (IFHP)**

Your Referring Laboratory's Reference #: \_\_\_\_\_

Billing address of hospital, referring laboratory:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov/State: \_\_\_\_\_

Postal/Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Telephone #: \_\_\_\_\_

**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:

\_\_\_\_\_