



NAME: _____

HSN: _____ Chart #: _____

D.O.B.: _____ M F

Ward/Location: _____

RUH SCH SPH Other _____

DEPARTMENT OF PATHOLOGY & LABORATORY MEDICINE

MOLECULAR MICROBIOLOGY/VIROLOGY REQUISITION

Requesting physician: _____
(First and last name)

Copy of report to: _____

Please submit a SEPARATE REQUISITION for *each* SPECIMEN TYPE

Collection date: _____ Collection time: _____ Collected by: _____

Clinical information: Immunocompromised Prenatal Outbreak # _____

Other clinical information: _____

SEROLOGY (Serum Antibody Tests) – Serum separator specimen required

<input type="checkbox"/> Epstein Barr Virus (EBV)	<input type="checkbox"/> Parvovirus B19 IgG	For CMV serology and Hepatitis A, B, & C serology – send specimen to CHEMISTRY using the following requisitions: <ul style="list-style-type: none"> • Inpatients: PHLEBOTOMY (Form #101062) • Outpatients: COMMUNITY (Form #101064)
<input type="checkbox"/> Herpes Virus (HSV) 1 & 2 IgG	<input type="checkbox"/> Parvovirus B19 IgM	
<input type="checkbox"/> Monospot (Monotest)	<input type="checkbox"/> Toxoplasma IgG	
<input type="checkbox"/> Mycoplasma pneumoniae IgM	<input type="checkbox"/> Varicella (VZV) IgG	
<input type="checkbox"/> Rubella IgG		

MOLECULAR (PCR) and ANTIGEN TESTS – Performed on specimen types indicated

<p>Respiratory Specimens</p> <input type="checkbox"/> Nasopharyngeal aspirate (NPA) <input type="checkbox"/> Nasopharyngeal swab (NPS) <input type="checkbox"/> Throat swab <input type="checkbox"/> Tracheal aspirate (TA) <input type="checkbox"/> Bronchial lavage (BAL) <i>(Specify lobe _____)</i> NOTE: Indicate above in Clinical Information if this is an outbreak <input type="checkbox"/> Respiratory Virus Screen <hr/> Other available tests: <input type="checkbox"/> Enteroviruses <input type="checkbox"/> Atypical bacteria (<i>Mycoplasma, Chlamydia</i>) <input type="checkbox"/> Pertussis bacteria (<i>B. pertussis, B. parapertussis</i>) <input type="checkbox"/> Legionella (<i>Only for BAL or TA</i>) <input type="checkbox"/> Cytomegalovirus (CMV) (<i>Only if immunocompromised</i>)	<p>Cerebrospinal Fluid</p> <input type="checkbox"/> Herpes & Varicella viruses (HSV-1 & 2, VZV) <input type="checkbox"/> Enteroviruses <hr/> Other available tests: <input type="checkbox"/> BK and JC viruses <input type="checkbox"/> Cytomegalovirus (CMV)	<p>Feces</p> NOTE: Indicate above in Clinical Information if this is an outbreak <input type="checkbox"/> Clostridium difficile <input type="checkbox"/> Enteroviruses <input type="checkbox"/> Norovirus <input type="checkbox"/> Rotavirus antigen	<p>Plasma (Lavender EDTA)</p> <i>Only if immunocompromised or transplants</i> <input type="checkbox"/> BK and JC viruses <input type="checkbox"/> West Nile Virus <input type="checkbox"/> Cytomegalovirus (CMV) viral load <input type="checkbox"/> Epstein Barr Virus (EBV) viral load NOTE: A single EDTA tube may be submitted if both the CMV and EBV viral load tests are requested.
	<p>Eye <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <input type="checkbox"/> Aqueous <input type="checkbox"/> Vitreous <input type="checkbox"/> Corneal scraping <input type="checkbox"/> Conjunctiva swab <input type="checkbox"/> Virus eye panel (Adenovirus, Herpes virus, Chlamydia trachomatis) <input type="checkbox"/> Cytomegalovirus (CMV) <input type="checkbox"/> Acanthamoeba	<p>Urine</p> <input type="checkbox"/> Cytomegalovirus (CMV) <input type="checkbox"/> BK and JC viruses	
		<p>Skin/Oral/Genital</p> <input type="checkbox"/> Herpes & Varicella viruses (HSV1 & 2/VZV) Specify site: _____	<p>Other Tests (Indicate type of specimen)</p>