

MOLECULAR AND GENOMIC PATHOLOGY SERVICES - INFECTIOUS DISEASES

All Information Must Be Completed Before Sample Can Be Processed. Please Type or Print.

PATIENT INFORMATION

Patient Name: _____, _____, _____ MI

Address: _____

Date of Birth ____/____/____ Phone: _____

Gender: ☐ Male ☐ Female MR# _____

ORDERING PHYSICIAN INFORMATION

Office/ Practice/ Institution Name: _____

Ordering Physician: _____

Street Address: _____

City: _____

State: _____ Postal Code: _____ Country: _____

Phone: _____ Fax: _____

Email Address: _____

BILLING INFORMATION

REFERRING INSTITUTION

Institution: _____

Address: _____

City/State/Zip: _____

Accounts Payable Contact Name: _____

Phone: _____

Fax: _____

Email: _____

*** Please note, we DO NOT bill the patient or their insurance unless they

are transferring care to Cincinnati Children's. ***

TEST(S) REQUESTED

- | | |
|---|---|
| ☐ Adenovirus (AV), qualitative
☐ Adenovirus (AV), quantitative
☐ BK Virus, qualitative
☐ BK Virus, quantitative
☐ <i>Bordetella pertussis/parapertussis</i> , qualitative
☐ <i>Cryptosporidium spp.</i> , qualitative
☐ Cytomegalovirus (CMV), qualitative
☐ Cytomegalovirus (CMV), quantitative
☐ Epstein-Barr Virus (EBV), qualitative
☐ Epstein-Barr Virus (EBV), quantitative
☐ Enterovirus (EV), qualitative
☐ Human Herpesvirus 6 (HHV6), qualitative
☐ Human Herpesvirus 6 (HHV6), quantitative
☐ Herpes Simplex Virus, Type 1 & 2 (HSV-1, HSV-2), qualitative
☐ HPV-6 & HPV-11, qualitative
☐ Influenza Virus A/B, qualitative
☐ Parvovirus, qualitative
☐ Parvovirus, quantitative
☐ <i>Pneumocystis jirovecii</i> , qualitative
☐ Respiratory Syncytial Virus (RSV), qualitative
☐ SARS-CoV-2 (COVID-19), qualitative
☐ COVID-19/Influenza A/B, qualitative
☐ Toxoplasma gondii, qualitative
☐ Varicella-Zoster Virus (VZV), qualitative | ☐ Atypical pneumonia panel, qualitative
☐ <i>Chlamydia pneumoniae</i>
☐ <i>Legionella pneumophila</i>
☐ <i>Mycoplasma pneumoniae</i>
☐ Viral PCR Panel (Cardiac), qualitative, includes: Adenovirus, CMV, EBV, EV, HHV6, Influenza Virus A/B, Parvovirus, RSV
☐ Meningitis/Encephalitis Panel, includes: <i>Escherichia coli</i> K1, <i>Haemophilus influenza</i> , <i>Listeria monocytogenes</i> , <i>Neisseria meningitidis</i> , <i>Streptococcus agalactiae</i> , <i>Streptococcus pneumoniae</i> , CMV, HSV1, HSV2, HHV6, EV, Parechovirus, VZV, <i>Cryptococcus gattii/neoformans</i>
☐ Syndromic Upper Respiratory Panel, includes: Adenovirus, Coronavirus (229E, HKU1, NL63, OC43, SARS-CoV-2 [COVID-19]), Metapneumovirus, Rhinovirus/Enterovirus, Influenza Virus A (H1, H1-2009, H3), Influenza Virus B, Parainfluenza Viruses 1/2/3/4, RSV, <i>C. pneumoniae</i> , <i>M. pneumoniae</i> , <i>B. pertussis</i> , <i>B. parapertussis</i> |
|---|---|

SAMPLE/SPECIMEN INFORMATION

Specimen Type: _____

All FFPE tissue samples must have an accompanying pathology report.

Collection Date/Time: _____

Phone # for questions: _____

Note: Please see test information sheet for acceptable specimen type, collection container, and volume.

Please ship materials to:

Cincinnati Children's Hospital Medical Center

Attn: Molecular and Genomic Pathology Services (MGPS)

3333 Burnet Avenue, R2.001

Cincinnati, OH 45229-3039

PHYSICIAN SIGNATURE

Ordering Physician Signature (REQUIRED) _____ Date: ____/____/____