

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: _____, _____, _____
Last First 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
- Bordetella pertussis/parapertussis*, qualitative
- Cryptosporidium spp.*, 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
- Pneumocystis jirovecii*, 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
- Chlamydia pneumoniae*
- Legionella pneumophila*
- Mycoplasma pneumoniae*
- Viral PCR Panel (Cardiac), qualitative, includes: Adenovirus, CMV, EBV, EV, HHV6, Influenza Virus A/B, Parvovirus, RSV
- Meningitis/Encephalitis Panel, includes: *Escherichia coli K1*, *Haemophilus influenzae*, *Listeria monocytogenes*, *Neisseria meningitidis*, *Streptococcus agalactiae*, *Streptococcus pneumoniae*, CMV, HSV1, HSV2, HHV6, EV, Parechovirus, VZV, *Cryptococcus gattii/neoformans*
- 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, *Chlamydia pneumoniae*, *Mycoplasma pneumoniae*, *Bordetella pertussis*, *Bordetella parapertussis*

SAMPLE/SPECIMEN INFORMATION

Specimen Type: _____

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

Phone: 513-636-9820

Fax: 513-517-7099

PHYSICIAN SIGNATURE

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