

**LONDON LABORATORY SERVICES GROUP
VIROLOGY REQUISITION**

ACCESSION NUMBER

Specimen & Source: _____

Collection Date/Time: _____
(YYYY/MM/DD / HH:MM)

Collected By: _____

STAT Phone results to: _____
(NAME) (EXT) (PAGER)

PIN: _____ UNIT: _____ ROOM #: _____

NAME: Last _____ First _____

ADDRESS: _____

SEX: _____ BIRTHDATE: YYYY/MM/DD _____ AGE: _____

OHC#: _____

PHYSICIAN: _____

ADDRESSOGRAPH LABEL HERE

Inpatient Outpatient

Ordering Physician: _____

Send Report to: _____

RELEVANT CLINICAL DIAGNOSIS AND HISTORY

Fever Lower R.I. Diarrhea Other _____

Headache Vomiting Rash Mac. Papul. _____

URI Neck Rigidity Rash Vesicular _____

Transplant Specify: _____ Pre-transplant Assessment Post Transplant

Senders Lab No: _____

SEROLOGY (Specimen Type: 5mL Gold Top Tube)

NOTE: Testing for IgG Antibody ONLY will be performed unless otherwise indicated.

<input type="checkbox"/> Bartonella (Cat Scratch)	<input type="checkbox"/> Mycoplasma pneumoniae	IgM Antibody for (specify): _____
<input type="checkbox"/> C. burnetii (Q Fever)	<input type="checkbox"/> Rubella	
<input type="checkbox"/> Cytomegalovirus (CMV)	<input type="checkbox"/> Toxoplasma	Date of onset of illness: _____
<input type="checkbox"/> Epstein Barr VCA (EBV)	<input type="checkbox"/> Varicella (VZV)	
<input type="checkbox"/> Herpes Simplex (HSV)	Other: (Use Public Health Requisition - LHSC Form Number 8460-5580)	
<input type="checkbox"/> Measles		
<input type="checkbox"/> Mumps		

CULTURE

Specimen Type: _____

Test for (specify): _____

Swabs must be submitted in Viral Transport Media (media available from HMMS, product number 36981)

PCR

Specimen Type: _____

Test for (specify): _____