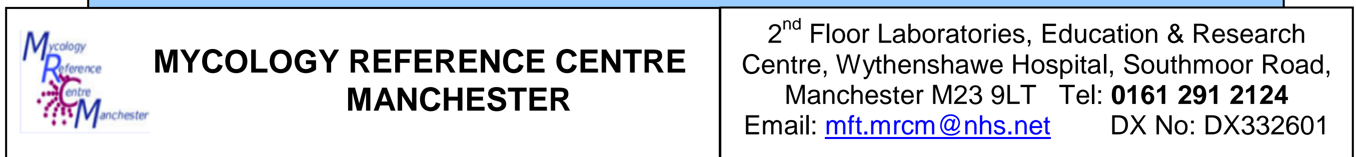

MYCOLOGY REFERENCE CENTRE MANCHESTER

2nd Floor Laboratories, Education & Research Centre, Wythenshawe Hospital, Southmoor Road, Manchester M23 9LT Tel: **0161 291 2124**
Email: mft.mrcm@nhs.net DX No: DX332601

Surname:*	**Forename:***

DOB:*	**M / F**	**NHS Number:*** **Hospital Number:***

Hospital:*	**Ward:***	**Requesting doctor:***

Lab No:*	**Date taken:***	**Specimen site:***

Address for results:*

Tel:
Email:
must be nhs.net

Clinical details, including travel history:

Please indicate if **high risk**: ☐

Tick if urgent: ☐ **and please inform the laboratory by telephone 0161 291 2124 prior to sending specimen**
*** Essential information**

TEST REQUESTS

Yeast ID/Susceptibility Testing
(please tick required drugs)

Culture ID if known: _________

Standard package: ☐
flucytosine, fluconazole, amphotericin, micafungin, anidulafungin, full ID and storage

HVS package: ☐
fluconazole, amphotericin, itraconazole, full ID and storage

Additional options:
- Caspofungin: ☐
- Itraconazole: ☐
- Voriconazole: ☐
- Posaconazole: ☐
- Ibrexafungerp: ☐

Identification only: ☐

Mould ID/Susceptibility Testing
(please tick required drugs)

Culture ID if known: _________

Standard package: ☐
itraconazole, amphotericin, voriconazole, posaconazole, full ID and storage

Additional options:
- Isavuconazole: ☐
- Terbinafine: ☐
- Micafungin: ☐
- Ibrexafungerp: ☐

Identification only: ☐

Examination of Hair, Skin and Nail: ☐

Please state site: ____________

Antifungal Level Assays
(please tick assay required)

- Flucytosine: ☐
- Itraconazole: ☐
- Posaconazole: ☐
- Voriconazole: ☐
- Isavuconazole: ☐
- Fluconazole: ☐

Pre-dose: ☐ Time: ______
Post-dose: ☐ Time: ______
Random: ☐ Time: ______

Please state ALL current antifungal therapy:

____

Interpretation depends on correct timings, and presence of other antifungals

Fungal Serology Tests (please tick assay required)

Aspergillus galactomannan ELISA:	Blood ☐	Bronchial wash ☐	Sputum ☐	Other: ______
Cryptococcal antigen:	Blood ☐	CSF ☐	Other: ______	
Aspergillus fumigatus precipitins:	Blood ☐			
Fungal glucan:	Blood ☐	Other: ________ (sputum is not appropriate for glucan testing)		

Fungal Molecular Tests (please tick assay required)

Aspergillus PCR (respiratory samples): ☐ Please state type of respiratory sample: _____________

Molecular resistance testing available upon request - please contact the laboratory