

THE REGIONAL MYCOLOGY LABORATORY, MANCHESTER (RMLM)		2 nd Floor Laboratory, Education and Research Centre, Wythenshawe Hosp., Southmoor Rd., Manchester M23 9LT. Tel: 0161 291 2124 Hayes DX No: DX6968700
Surname*		Forename*
DOB:*	M/F	NHS Number:* Hospital Number: *

Hospital*	Ward*	Requesting consultant/MO:
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Lab No.*	Date and time taken/isolated:*	Specimen site:*
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Address for results:* Tel:	Clinical details, including ALL current antifungal therapy: Please indicate if high risk: <input type="checkbox"/>
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Tick if urgent: <input type="checkbox"/> and please inform the laboratory by telephone prior to sending specimen * Essential information

TEST REQUESTS

Yeast Susceptibility Testing (please tick required drugs) Culture ID if known: _____ Standard package = flucytosine, fluconazole, amphotericin B, caspofungin, anidulafungin, full ID and long term storage: <input type="checkbox"/> Additional options: Itraconazole: <input type="checkbox"/> Voriconazole: <input type="checkbox"/> Micafungin: <input type="checkbox"/> Other (please specify): _____ Identification only: <input type="checkbox"/>	Mould Susceptibility Testing (please tick required drugs) Culture ID if known: _____ Standard package = itraconazole, amphotericin B, voriconazole, posaconazole, full ID and long term storage: <input type="checkbox"/> Other (please specify): _____ Identification only: <input type="checkbox"/>	Antifungal Level Assays (please tick which assay required) Flucytosine: <input type="checkbox"/> Fluconazole: <input type="checkbox"/> Itraconazole: <input type="checkbox"/> Posaconazole: <input type="checkbox"/> Voriconazole: <input type="checkbox"/> Please state: Pre-dose: <input type="checkbox"/> Time: _____ Post-dose: <input type="checkbox"/> Time: _____ Random: <input type="checkbox"/> Time: _____ Current dose: _____ Time last dose given: _____ <i>Interpretation depends on correct timings, and presence of other antifungals</i>
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Fungal Serology Tests (please tick assay required)	
<i>Aspergillus</i> galactomannan ELISA:	<input type="checkbox"/>
Cryptococcal antigen:	<input type="checkbox"/>
<i>Aspergillus fumigatus</i> precipitins:	<input type="checkbox"/>
<i>A. fumigatus</i> and other aspergilli precipitins:	<input type="checkbox"/>

Examination and culture of skin, hair and nail: <input type="checkbox"/>
