



**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: <i>must be nhs.net</i>	Clinical details, including <u>travel history</u>: Please indicate if high risk : <input type="checkbox"/>
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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: _____ <i>Standard package</i> : <input type="checkbox"/> flucytosine, fluconazole, amphotericin, micafungin, anidulafungin, full ID and storage <i>HVS package</i> : <input type="checkbox"/> fluconazole, amphotericin, itraconazole, full ID and storage Additional options: Caspofungin: <input type="checkbox"/> Itraconazole: <input type="checkbox"/> Voriconazole: <input type="checkbox"/> Posaconazole: <input type="checkbox"/> Ibrexafungerp: <input type="checkbox"/> Identification only : <input type="checkbox"/>	Mould ID/Susceptibility Testing (please tick required drugs) Culture ID if known: _____ <i>Standard package</i> : <input type="checkbox"/> itraconazole, amphotericin, voriconazole, posaconazole, full ID and storage Additional options: Isavuconazole: <input type="checkbox"/> Terbinafine: <input type="checkbox"/> Micafungin: <input type="checkbox"/> Ibrexafungerp: <input type="checkbox"/> Identification only : <input type="checkbox"/> Examination of Hair, Skin and Nail : <input type="checkbox"/> Please state site: _____	Antifungal Level Assays (please tick assay required) Flucytosine: <input type="checkbox"/> Itraconazole: <input type="checkbox"/> Posaconazole: <input type="checkbox"/> Voriconazole: <input type="checkbox"/> Isavuconazole: <input type="checkbox"/> Fluconazole: <input type="checkbox"/> Pre-dose: <input type="checkbox"/> Time: _____ Post-dose: <input type="checkbox"/> Time: _____ Random: <input type="checkbox"/> Time: _____ Please state ALL current antifungal therapy: _____ <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:	Blood <input type="checkbox"/>	Bronchial wash <input type="checkbox"/>	Sputum <input type="checkbox"/>	Other: _____
Cryptococcal antigen:	Blood <input type="checkbox"/>	CSF <input type="checkbox"/>	Other: _____	
<i>Aspergillus fumigatus</i> precipitins:	Blood <input type="checkbox"/>			
Fungal glucan:	Blood <input type="checkbox"/>	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