FUNGUS TESTING LABORATORY REQUISITION

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO
DEPARTMENT OF PATHOLOGY
7703 FLOYD CURL DRIVE SAN ANTONIO, TX 78229-3900
(210) 567-4131 / FAX: (210) 567-4076
www.strl.uthscsa.edu provides shipping/specimen specific requirements

From: _____ Date: _____
_____ Phone: _____
_____ Contact: _____
_____ Diagnosis: _____
FAX: _____ Physician: _____

Patient: _____ Pt. ID #: _____

TESTS REQUESTED
Submit organism in pure culture

Isolate: _____

Your culture #: _____ Source: _____

SUSCEPTIBILITY TESTING ($65.00/Drug) CPT 87186 yeast, CPT 87188 mould
****MLC** Minimum Lethal Concentration - CPT 87187 (performed by request only $15/drug)

			MLC				MLC				MLC
_____	AMB	Amphotericin B	____	_____	NYS	Nystatin	____	_____	NAT	Natamycin	____
_____	5-FC	5-Fluorocytosine		_____	CAS	Caspofungin		_____	FLU	Fluconazole	
_____	ITRA	Itraconazole		_____	KETO	Ketoconazole		_____	MON	Miconazole	
_____	CLOT	Clotrimazole		_____	TERC	Terconazole		_____	TERB	Terbinafine	
_____	GRIS	Griseofulvin		_____	VORI	Voriconazole		_____	POS	Posaconazole	
_____	MICA	Micafungin		_____	ANID	Anidulafungin		_____	Other	_____	

_____**AZOLE PANEL** ($200.00 FLU, ITRA, VORI, POSA) _____ **AMB/CANDIN PANEL** ($200.00 AMB/ANID/CAS/ MICA)

SYNERGY STUDIES Combined Drug Therapy ($150.00/test * NOTE: a $65/individual drug charge also applies) (CPT 87999 - misc. micro)

____ _____ + _____ ____ _____ + _____
____ _____ + _____ ____ _____ + _____

FUNGAL IDENTIFICATION
Identification is by combined phenotypic characterization and molecular sequencing
Please NOTE: Requisition for Research Epidemiology/Relatedness Studies available at www.strl.uthscsa.edu or via FAX

____ Identification ($240.00) (CPT for yeast 87153 plus 87106/CPT for moulds 87153 plus 87107)
____ DNA Probe – _____*Coccidioides immitis/posadasii* _____ *Blastomyces dermatitidis* _____ *Histoplasma capsulatum* ($155.00) (CPT 87797)

ANTIFUNGAL DRUG LEVELS
$120.00/Specimen CPT 82491 HPLC/LCMS
Specimen requirements: 1 ml plasma/serum spun-down and separated. Must remain frozen and be shipped on ice packs/dry ice.

Specimen: _____ Date/Time Drawn: _____ Dose: _____
Date/Time Last Dose: _____

____	Amphotericin B	____	5-fluorocytosine	____	Fluconazole	____	Itraconazole
____	Posaconazole	____	Voriconazole	____	Ketoconazole	____	_____
____	Anidulafungin	____	Caspofungin	____	Micafungin	____	_____

Please indicate all antifungal agents patient is receiving at time of collection: _____