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) 614-4250 or (210) 567-4076
http://strl.uthscsa.edu provides shipping/specimen specific requirements

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

Patient: _____ Pt. ID & DOB#: _____

TESTS REQUESTED
(Submit organism in pure culture)

Species: _____ Collection Date: _____

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		____	REZA	Rezafungin		____	MON	Miconazole	
____	CLOT	Clotrimazole		____	TERC	Terconazole		____	TERB	Terbinafine	
____	GRIS	Griseofulvin		____	VORI	Voriconazole		____	POS	Posaconazole	
____	MICA	Micafungin		____	ANID	Anidulafungin		____	ISA	Isavuconazole	
____	Other	_____		____	Other	_____		____	Other	_____	

FUNGAL IDENTIFICATION
Identification is by combined phenotypic characterization and DNA sequencing or MALDI-TOF MS

____ Routine Identification Moulds by DNA sequencing and phenotypic characterization ($240.00) CPT 87153 plus 87107

____ Routine Identification Yeasts by DNA sequencing and phenotypic characterization ($240.00) CPT for yeast 87153 plus 87106 (**NO** MALDI-TOF MS performed)

____ MALDI-TOF MS for Yeasts CPT 87106 ($120.00 MALDI-TOF MS only; reflex to Routine Identification above if no identification by MALDI-TOF MS, total cost $240.00)

ANTIFUNGAL DRUG LEVELS
$120.00/Assay or Specimen CPT 80187 Posaconazole, 80285 Voriconazole, 80189 Itraconazole, 80299 for others (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	____	Fluconazole	____	Isavuconazole
____	Voriconazole	____	Posaconazole	____	Itraconazole

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

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BILLING TO INSTITUTIONS AND PHYSICIANS ONLY