THE REGIONAL MYCOLOGY LABORATORY, MANCHESTER (RMLM)

2nd 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:**

Lab No.* **Date and time taken/isolated:*** **Specimen site:***

Address for results:*

Tel:

Clinical details, including ALL current antifungal therapy:

Please indicate if **high risk**: ☐

Tick if urgent: ☐ **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: ☐

Additional options:
Itraconazole: ☐
Voriconazole: ☐
Micafungin: ☐

Other (please specify):________________

Identification only: ☐

Mould Susceptibility Testing
(please tick required drugs)

Culture ID if known:________

Standard package = itraconazole, amphotericin B, voriconazole, posaconazole, full ID and long term storage: ☐

Other (please specify):

____

Identification only: ☐

Antifungal Level Assays
(please tick which assay required)

Flucytosine: ☐
Fluconazole ☐
Itraconazole: ☐
Posaconazole: ☐
Voriconazole: ☐

Please state:
Pre-dose: ☐ Time:______
Post-dose: ☐ Time:______
Random: ☐ Time:______
Current dose:______________
Time last dose given:________
Interpretation depends on correct timings, and presence of other antifungals

Fungal Serology Tests (please tick assay required)

Aspergillus galactomannan ELISA: ☐
Cryptococcal antigen: ☐
Aspergillus fumigatus precipitins: ☐
A. fumigatus and other aspergilli precipitins: ☐

Examination and culture of skin, hair and nail: ☐