

Testing in Non-Pregnant Adults and Older Children (more than 1 year of age)

Patient Information: *Patient name and collection date must also appear on specimen label.*

Patient's Last Name: _____, First Name: _____ Birth date: _____ Gender: _____
 Patient ID#: _____ Specimen type: _____ Collection date: _____
 Physician's Name: _____ Phone: _____
 Physician's Address: _____ Fax: _____

History (important for proper interpretation of results)

<p>Immunocompromised <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> HIV <input type="checkbox"/> AIDS CD4 count _____ <input type="checkbox"/> Other (please specify) _____</p> <p>Lymphadenopathy <input type="checkbox"/> N <input type="checkbox"/> Y Date of onset _____ Location of node(s) _____ ▶Please include a copy of biopsy report if performed</p> <p>Eye disease <input type="checkbox"/> N <input type="checkbox"/> Y Eye findings _____ <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral <input type="checkbox"/> Macular involvement <input type="checkbox"/> Peripheral retinal disease</p> <p>Hepatitis <input type="checkbox"/> N <input type="checkbox"/> Y Date of onset _____ Liver Function Tests _____</p>	<p>Myocarditis and/or Polymyositis <input type="checkbox"/> N <input type="checkbox"/> Y Date of onset _____ Creatine Kinase (CK) _____ Myocardial enzymes _____</p> <p>Encephalitis <input type="checkbox"/> N <input type="checkbox"/> Y Date of onset _____ Other Please specify _____</p> <p>Symptoms <input type="checkbox"/> None <input type="checkbox"/> Fever <input type="checkbox"/> Flu-like symptoms <input type="checkbox"/> Other _____</p> <p>Risk Factor(s) (or exposure) <input type="checkbox"/> Ingestion of raw or undercooked meat <input type="checkbox"/> Cat feces <input type="checkbox"/> Gardening <input type="checkbox"/> None <input type="checkbox"/> Other _____</p> <p>Toxoplasma test results from other laboratory IgG: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg IgM: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg <input type="checkbox"/> Other (please specify) _____ ▶Please include a copy of the report if available</p>
---	--

Recommended Tests

*For patients reported to have **positive IgM** results by another laboratory or suspected to have acute toxoplasmosis*

<input type="checkbox"/> IgG (Dye test), IgM ELISA, Avidity	\$445
<input type="checkbox"/> Reflex to other tests in the Toxoplasma Panel as indicated *	\$395
OR	
<input type="checkbox"/> IgG (Dye test), IgM ELISA	\$289
<input type="checkbox"/> Reflex to Avidity, and/or other tests in the Toxoplasma Panel as indicated *	\$551

For initial Toxoplasma serology screening

<input type="checkbox"/> IgG (Dye test), IgM ELISA	\$289
<input type="checkbox"/> Reflex to Avidity, and/or other tests in the Toxoplasma Panel as indicated *	\$551

Other Test Options

Individual tests

<input type="checkbox"/> IgG (Dye Test)	\$144
<input type="checkbox"/> IgM ELISA	\$152
<input type="checkbox"/> IgA ELISA	\$149
<input type="checkbox"/> AC/HS	\$168
<input type="checkbox"/> Avidity; IgG (Dye test) and IgM ELISA will also be performed	\$445
<input type="checkbox"/> PCR (see PCR specimen requirements)	
<input type="checkbox"/> Solid tissues (specimen type) _____	\$430
<input type="checkbox"/> Whole blood, other body fluids (specimen type) _____	\$398
<input type="checkbox"/> Isolation of <i>T. gondii</i> (specimen type) _____	\$527

Panels

<input type="checkbox"/> Toxoplasma Panel (IgG (Dye test), IgM ELISA, IgA ELISA, IgE ELISA, AC/HS)	\$684
---	-------

*Our TSL physicians will review results and select appropriate test(s) in the Toxoplasma Panel (IgG (Dye Test); IgM ELISA, IgA ELISA and IgE ELISA; AC/HS).

Client's Billing address (MUST be included. We cannot bill the patient or insurance.)

Results address

Attn:

Attn:

PO# (if required for payment):

Phone: _____ Fax: _____

Phone: _____ Fax: _____

E-mail:

Email:

Send to: Toxoplasma Serology Laboratory, PAMF Ames Building, 795 El Camino Real, Palo Alto, CA 94301
 Tel: (650) 853-4828 Fax: (650) 614-3292 Email: toxolab@pamf.org Web site: www.pamf.org/serology

For laboratory use only:

Customer number: _____	Specimen condition:
Doctor number: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Hemolyzed <input type="checkbox"/> Icteric <input type="checkbox"/> Lipemic
Accession number: _____	Other: _____