

Testing in Immunocompromised Patients

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)

Category of Immunosuppression

HIV AIDS CD4 count _____

Symptoms None Fever Flu-Like symptoms

Other _____

Transplant

Bone Marrow HSCT
 Pre-Transplant Post Transplant
 Donor Recipient

Hepatitis N Y

Eye Disease N Y

Eye findings: _____
 Bilateral Unilateral Macular involvement Peripheral retinal disease

Solid Organ Transplant

Heart Lung Kidney Liver Pancreas Bowel

Encephalitis N Y Date of onset _____

Immunosuppressive Drugs

Corticosteroids Anti-TNF Drugs
 Other (please specify) _____

Pneumonia N Y Date of onset _____

Myocarditis and/or Polymyositis N Y Date of onset _____

Creatine Kinase (CK) _____ Myocardial Enzymes _____

Cancer

Please specify Absolute Neutrophil Count _____
 Pre-Chemotherapy On Chemotherapy Post Chemotherapy

Toxoplasma test results from other laboratory IgG: Pos. Neg.
 IgM: Pos. Neg.

Other (please specify) _____

▶ Please include a copy of the report if available

Recommended Tests

IgG (Dye test), IgM ELISA, Avidity \$385
 Reflex to other tests in the Toxoplasma Panel as indicated* \$338

PCR in body fluids or tissue according to history and symptoms
 (see PCR specimen requirements)

Solid tissues (specimen type) _____ \$408

Whole blood, bronchoalveolar lavage fluid, vitreous fluid,
 other body fluids (specify) _____ \$379

Other Test Options

Individual tests

IgG (Dye Test) \$123
 IgM ELISA \$130
 IgA ELISA \$133
 AC/HS \$142
 Avidity: IgG (Dye test) and IgM ELISA will also be performed \$385
 Isolation of *T. gondii* (specimen type) _____ \$434

Panel

Toxoplasma Panel \$581
 (IgG (Dye test), IgM ELISA, IgA ELISA, IgE ELISA, AC/HS)

*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: _____	Phone: _____	Fax: _____
E-mail: _____		Email: _____	

Send to: Toxoplasma Serology Laboratory, Ames Building PAMF/RI, 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: _____ Normal Hemolyzed Icteric Lipemic
 Accession number: _____ Other: _____

