

**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)

	<b>MLC</b>		<b>MLC</b>		<b>MLC</b>
_____ AMB	Amphotericin B	_____ NYS	Nystatin	_____ NAT	Natamycin
_____ 5-FC	5-Fluorocytosine	_____ CAS	Caspofungin	_____ FLU	Fluconazole
_____ ITRA	Itraconazole	_____ IBX	Ibrexafungerp	_____ MON	Miconazole
_____ CLOT	Clotrimazole	_____ TERC	Terconazole	_____ TERB	Terbinafine
_____ GRIS	Griseofulvin	_____ VORI	Voriconazole	_____ POS	Posaconazole
_____ MICA	Micafungin	_____ ANID	Anidulafungin	_____ ISA	Isavuconazole
_____ REZA	Rezafungin	_____ Other	_____	_____ Other	_____

**FUNGAL IDENTIFICATION**

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

- \_\_\_\_\_ Routine Identification Moulds (\$240.00) CPT 87153 plus 87107
- \_\_\_\_\_ Routine Identification Yeasts (\$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/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: \_\_\_\_\_