MICROBIOLOGY TEST REQUEST FORM

Laboratory of Clinical Diagnostics

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SELF-PAYING PATIENTS SHOULD FILL OUT ONLY THE HIGHLIGHTED BOXES

Personal ID Number / Insurance Number

Date of Birth . .

Sex: ☑ Female ☑ Male

Surname

First Name

Email[1)]

Phone number [1)]

Address (Street name, City, ZIP Code)

☐ Self-pay patient ☐ Insurance company:

Physician[2)] (stamp, signature, specialization, Provider Identification Number):

Tick-borne encephalitis vaccination details, antibiotic treatment, clinical information:

Diagnoses [2)] :

Date and time of specimen collection, collected by:

Collected material: ☐ blood ☐ nosopharyngeal swab ☐ other: _____

Vaccination Status Check (IgG)

- ☐ **Tick-borne encephalitis** (IgG) - ELISA
- ☐ **Tick-borne encephalitis** - virus neutralization test

Serology of Infectious Diseases

- ☐ **Borrelia** (IgG, IgM)
  (ELISA + confirmatory Western Blot in case of a positive result)

Molecular Detection of Pathogens

- ☐ **SARS-CoV-2**
- ☐ **Respiratory Viral Infections (multiplex)**
  - Influenza A / Influenza B
  - Adenovirus
  - Parainfluenza
  - Rhinovirus
  - Metapneumovirus
  - Respiratory syncytial virus (RSV)
- ☐ **Bacterial Pneumonia (Multiplex)**
  - Bordetella pertusis
  - Bordetella parapertussis
  - Chlamydia pneumoniae
  - Haemophilus influenzae
  - Legionella pneumophila
  - Mycoplasma pneumoniae
  - Streptococcus pneumoniae

Received, LKD sample identification:

[1)] Required for self-paying patients
[2)] To be completed by physician

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