Dr. Jack S. Remington Laboratory for Specialty Diagnostics
formerly known as the Toxoplasma Serology Laboratory

Sutter Health
Palo Alto Medical Foundation

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____________________

Transplant
❑Bone Marrow ❑HSCT
❑Pre-Transplant ❑Post Transplant
❑Donor ❑Recipient

Solid Organ Transplant
❑Heart ❑Lung ❑Kidney ❑Liver ❑Pancreas ❑Bowel

Immunosuppressive Drugs
❑Corticosteroids ❑Anti-TNF Drugs
❑Other (please specify)____________________

Cancer
Please specify Absolute Neutrophil Count____________________
❑Pre-Chemotherapy ❑On Chemotherapy ❑Post Chemotherapy

Symptoms ❑None ❑Fever ❑Flu-Like symptoms
❑Other____________________

Hepatitis ❑N ❑Y

Eye Disease ❑N ❑Y
Eye findings____________________
❑Bilateral ❑Unilateral ❑Macular involvement ❑Peripheral retinal disease

Encephalitis ❑N ❑Y Date of onset____________________

Pneumonia ❑N ❑Y Date of onset____________________

Myocarditis and/or Polymyositis ❑N ❑Y Date of onset__________
Creatine Kinase (CK)__________ Myocardial Enzymes__________

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), Remington IgM ELISA, Avidity $546
❑Reflex to other tests in the Toxoplasma Panel as indicated* $526

PCR in body fluids or tissue according to history and symptoms
(see PCR specimen requirements)
❑Solid tissues (specimen type) $485
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❑Whole blood, bronchoalveolar lavage fluid, vitreous fluid, other body fluids (specify) $465
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Other Test Options

Individual tests (Preferred)
❑IgG (Dye Test) $180
❑Remington IgM ELISA $185
❑Remington IgA ELISA $180
❑AC/HS $196
❑Avidity: For clinical recommendations IgG (Dye test) and IgM ELISA are required $196

❑Isolation of *T. gondii* (specimen type)____________________ $677

Panel
❑Toxoplasma Panel $876
(IgG (Dye test), Remington IgM ELISA, Remington IgA ELISA, Remington IgE ELISA, AC/HS)

***If parallel testing is indicated a $90.00 per test charge will be added.**

*Our Remington Lab 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.)***

Attn:

PO# (if required for payment):

Phone: **Fax:**

E-mail:

Results address

Attn:

Phone: **Fax:**

Email:

Send to: Dr. Jack S. Remington Laboratory for Specialty Diagnostics, 795 El Camino Real, Ames Building, Palo Alto, CA 94301
Tel: (650) 853-4828 Fax: (650) 614-3292 Email: RemingtonLab@sutterhealth.org Web site: www.sutterhealth.org/RemingtonLab

For laboratory use only:
*Customer number:*____________________
*Doctor number:*____________________
*Accession number:*____________________
Specimen condition:
❑*Normal* ❑*Hemolyzed* ❑*Icteric* ❑*Lipemic*
Other: ____________________