

ORDER FORM DIAGNOSTIC EXAMINATION OCULAR FLUID

**University Medical Center Utrecht
Division Laboratory and Pharmacy
Clinical Virology**

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General patient information	
Name:	
Address:	
Date of Birth:	
Gender:	

Senders information	Billing address
Hospital:	Institution:
Physician:	Address:
Address:	Phone:
Phone:	Email:
Date:	

Material			
<input type="checkbox"/> serum	<input type="checkbox"/> Aqueous OD	<input type="checkbox"/> Vitreous OD	N.B. Always send serum or EDTA blood with ocular fluids.
<input type="checkbox"/> EDTA blood	<input type="checkbox"/> Aqueous OS	<input type="checkbox"/> Vitreous OS	

Clinical data			
Suspected clinical diagnosis			
Uveitis			Remarks:
<input type="checkbox"/> OD	<input type="checkbox"/> anterior	<input type="checkbox"/> active
<input type="checkbox"/> OS	<input type="checkbox"/> posterior	<input type="checkbox"/> non-active
<input type="checkbox"/> ODS	<input type="checkbox"/> intermediair	
	<input type="checkbox"/> pan	
Medication			
<input type="checkbox"/> none	<input type="checkbox"/> immunosuppressives	<input type="checkbox"/> other	
<input type="checkbox"/> prednison	<input type="checkbox"/> antiviral therapy		

Question			
Please mark the tests you wish to have performed.			
Because of limited volume, please indicate the priority of the pathogens to test for. Circle the number, where 1 is the highest priority.			
	PCR	GWC (Antibodies)	Priority
HSV	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5 6
VZV	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5 6
Toxoplasma	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5 6
CMV	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5 6
Rubella virus	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5 6
Parvovirus B19	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5 6
M. tuberculosis	<input type="checkbox"/>	not applicable	1 2 3 4 5 6
Treponema (syphilis)	<input type="checkbox"/>	not applicable	1 2 3 4 5 6
Toxocara	not applicable	<input type="checkbox"/>	1 2 3 4 5 6
.....	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5 6