| Title | Clinical Microbiology User Handbook | | |
|---|---|---|---|
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NHS
University Hospitals of Leicester
NHS Trust

# Clinical Microbiology User Handbook

## A user guide for UHL Clinical Microbiology Pathology services

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# Contents

# 1 Purpose of Document

**This handbook is intended to serve as a quick user guide to the services available from the Clinical Microbiology Laboratory of the University Hospitals of Leicester NHS (National Health Service) Trust. It is aimed at all staff groups involved with the Microbiological investigations. It is reviewed on a regular basis, or where significant changes are made to the service. The list of tests available can be found in section 19 of this document.**

## 2 Measurement Uncertainty and Risk Management

Within any laboratory process or procedure there will always be a degree of variability. These will vary with specimen type and test. Test-specific information on the processes we use to minimise this variability is available on request.

## 3 Overview of Services

The Clinical Microbiology Laboratory is part of Pathology service within the University Hospitals of Leicester NHS Trust. The postal address is:

**Clinical Microbiology**
**University Hospitals of Leicester NHS Trust**
**Level 5 Sandringham Building**
**Leicester Royal Infirmary**
**Infirmary Square**
**Leicester LE1 5WW**

**DX number:** 6770100
**Exchange:** LEICESTER 90 LE

The Laboratory provides the following services:

- Diagnostic services for hospital clinical staff and general practitioners working in the community.
- Antibiotic stewardship and infection management advice.
- Infectious Diseases in Pregnancy Screening (IDPS) as part of the Antenatal Screening Programme
- Support to Consultants in Communicable Disease Control and their colleagues UKHSA (UK Health Security Agency) (Formerly Public Health England).
- Local surveillance and special studies in infectious disease.
- Investigation and support in community and national outbreaks of communicable disease.
- Independently funded clinical and other related services.

The patients' well-being, safety and rights are our primary consideration. The laboratory achieves this by treating each specimen with a quality centred approach from specimen receipt to final report.

The Clinical Microbiology Laboratory is situated at the Leicester Royal Infirmary (LRI). Some urgent respiratory (including SARS-CoV-2) testing is also undertaken at Glenfield Hospital (GH). The services provided within the department are Bacteriology, Virology / Molecular, Mycology & Parasitology. Please note that examination of blood samples for malarial parasites is undertaken by Haematology.

# 4 Quality & Governance

8605

**Accredited to ISO 15189:2022**

The Microbiology Laboratory participates in a full range of National Quality Assurance Schemes. It is a UKAS accredited medical laboratory No. 8605, currently accredited to ISO 15189:2022. Evidence of accreditation to this standard, along with details of our Schedule of Accreditation outlining the scope of work for which have been assessed is available at:
https://www.ukas.com/download-schedule/8605/Medical

The department is currently implementing a revised reporting format to align with the requirements of the UKAS ISO 15189:2022 requirements. As part of this this transition, reports will clearly indicate which tests have been accredited to this standard.

In the updated format, accreditation will be marked by annotating with asterisk as follows:

(*)- This test is provided by a UKAS accredited medical laboratory No.8605. Test currently accredited.
(**)- Not accredited - This test is not UKAS accredited.
(***) – This test is not currently UKAS accredited but is in the process of being applied for UKAS accreditation.
This notation is intended to provide clarity and assurance regarding compliance with the quality and accreditation requirements.
During the transition period, reports may contain a mixture of annotated and non-annotated reports. Users are advised to take note of the asterisk symbol or refer to the UKAS website referred to above if not clear.

## 4.1 Complaints Procedure

A complaint may be made via any normal means of communication:

- To the NHS Trust – normally via the Patient Advice and Liaison Service (PALS), who will direct relevant aspects of any complaint to the laboratory. PILS can be contacted on 0808 178 8337 or uhl-tr.pals@nhs.net.
- To the laboratory directly via 0116 2586542 – normally to the Head of Service or General Manager.

## 4.2 Confidentiality

The laboratory is committed to maintaining patient confidentiality and practices Caldicott principles. At times this will mean that electronic communications (phone or email) to and from the laboratory may be constrained

by protocols intended to preserve patient confidentiality. These controls will be in accordance with professional and regulatory guidance.
Laboratory staff follow the Trust policy on Information Governance (available on UHL Connect Information Governance | Digital and Data - UHL Connect)

Microbiology sample requests are an agreement between the service and the user for the testing and confirmation of the infection markers indicated.

**For further details please go to section 15 in this document**

## 5 Key Personnel

| General Numbers | Extension | e-mail |
|---|---|---|
| Administration office | 0116 258 6508/16542/6536 | |
| Bacteriology Laboratory | 0116 258 16546 | |
| Virology Laboratory | 0116 258 6522/5568 | |
| Consultant Medical Microbiologist | | |
| Dr F. Lim (Head of Service) | Request for clinical advice should be directed via electronic referrals or the on-call microbiologist to ensure timely response. Between 09:00 and 17:00, please ring the Microbiology Doctors on **07811024829**.<br><br>Out of hours Please contact the UHL Switchboard and ask for the "On Call Microbiology Registrar".<br>`See section 8 below for further details. | |
| Dr D. Jenkins | | |
| Dr S. Koo | | |
| Dr S.S. Bukhari | | |
| Dr R Saunders | | |
| Dr J. Veater | | |
| Dr D. Modha | | |
| Dr G. Hills | | |
| Dr N. Perera | | |
| Dr D. Jamal khan | | |
| Prof. M. Barer (Professor of Clinical Microbiology and Honorary Consultant) | | |
| Dr C Holmes (Consultant Clinical Scientist) | 07483 938822/ 0116 204 7961. | c.holmes1@nhs.net |
| Consultant Virologists | | |
| Dr J. Tang | 0116 258 6516/16542/ | julian.tang6@nhs.net |
| Dr O. Toovey | 0116 258 6516/16542 | o.toovey@nhs.net |
| Virology clinical advice can be obtained during normal working hours either by phoning the virology office and/or e-mailing the virology consultants. We do not provide an out of hours service. For virology clinical advice out of hours, please contact the on-call microbiology doctor | | |
| Service Managers and other key roles | | |
| Jilean Bowskill-General Manager | 0116 258 6504 | Jilean.bowskill@nhs.net |
| Purvi Shah- Scientific Laboratory Manager (Bacteriology), Health & Safety. *Currently on maternity leave* | 0116 258 6541 | purvi.shah12@nhs.net |
| Hiten Mistry- Scientific Laboratory Manager (Virology), IT | 0116 258 6535 | hiten.mistry5@nhs.net |
| Daxa Patel-Quality & Service Improvement Manager | 0116 258 6646 | daxa.patel11@nhs.net |

| | | |
|---|---|---|
| Karan Gorania- Quality Lead/IT Manager | 0116 2586514/ 2586524/ 2586510 | karan.gorania@nhs.net |
| Judi Gardener-Quality Lead | 0116 258 6522/5568 | judi.gardener@nhs.net |
| Richard Halliwell- Training Lead | 0116 2586514/ 2586524/ | richard.halliwell@nhs.net |
| Arjun Bhatt – Health and Safety Lead | 0116 2586514/ 2586524 /2586510 | arjun.bhatt@nhs.net |
| Research and Development Team | 0116 204 7961 | Uhl-tr.microbiologyRDI@nhs.net |

# 6 Opening Hours and Telephone Numbers

## Laboratory Hours – Non-Medical Staff (normal working for 'routine' work)

| | Virology | Bacteriology |
|---|---|---|
| **Monday – Friday** | **07:00 – 21:30** | **08:00 - 20:00** |
| **Saturday** | **07:00 – 21:30** | **08:00 - 16:00** |
| **Sunday** | **07:00 – 21:30** | **08:00 - 12:00** |

| | Routine Hours | Out of Hours |
|---|---|---|
| **Urgent Bacteriology Samples** | **Ext.16520** | **On call BMS via switchboard** |
| **Routine Bacteriology at LRI** | **Ext 16546** | |
| **Virology Department at LRI** | **Ext.16522 or 15568** | **Ext.16522 or 15568** |
| **Respiratory testing lab at GGH** | **Ext.13805/13489** | **Ext.13805/13489** |
| **Medical Staff (for advice)** | **Refer to Section 8 and 9** | **Via switchboard (See 9.2 below)** |

**[*see section 10:* urgent specimens/out of hours specimens*]***

**For all results please refer to ICE or Nervecentre – do NOT contact the laboratory (unless exceptional circumstances e.g. urgent result not available on ICE or Nervecentre)**

Results enquiries are available during routine hours only.

## 7 Results Telephoned to Clinicians by Medical Staff

Not all results are phoned out, please refer to individual tests for further details. The following results are telephoned to clinicians by the Microbiology Medics (or Biomedical Scientist):

### Bacteriology

- **Blood Cultures:**
  - Potentially significant blood culture Gram stain results
  - Significant positive blood culture isolate results if they require a change in patient management or further microbiology input
- **Cerebrospinal Fluid (CSF) samples:**
  - Positive CSF microscopy results (Biomedical Scientist)
  - Significant positive CSF culture results
  - Cryptococcal antigen positive results
- **Eye Samples:**
  - Positive vitreous fluid cultures results
  - Acanthamoeba positive results
  - Corneal scrapes with positive fungal results
  - Positive eye sample results for *Neisseria meningitidis*, *Neisseria gonorrhoeae* and *Chlamydia trachomatis*
- **Respiratory samples for inpatients:**
  - Positive *Legionella* urinary antigen results
  - Positive *Bordetella pertussis* culture results
  - Smear-positive or PCR-positive TB sample results
- Outside the normal working hours of the Infection Prevention and Control team, any new result that requires a change in source isolation precautions

## 8 Medical Advice

| Laboratory Hours – Medical Staff | | |
|---|---|---|
| | **Normal Working Hours** | **On-Call Microbiologist** |
| **Monday – Friday** | **09:00 – 17:00** | **17:00-09:00** |
| **Saturday – Sunday** | | **All day** |
| **Bank Holidays** | | **All day** |

Advice on patient diagnosis, specimens to be taken, the interpretation of results and the use of antibiotics can be obtained from the laboratory during normal working hours (see contact details above). An updated copy of the on-call rota is kept on Medirota and accessed by UHL switchboard.

Please note that many queries regarding empiric antimicrobial prescribing are addressed on UHL EOLAS Website or for GPs – Leicester, Leicestershire and Rutland: Antimicrobial Policy and Guidance for Primary Care' produced by Leicester, Leicestershire and Rutland Area Prescribing Committee - please check the appropriate sites BEFORE contacting Microbiology.

For web go here: https://app.eolasmedical.com/auto-login/EOLAS%23ORG%23staging-university-hospitals-of-leicester-nhs-trust%23073af352-6cdf-4b8f-bb38-defbbd40bc01%23c3ed2506-57ec-47d5-a20e-988486576deb

For mobile go here: https://app.eolasmedical.com/access-link/10af0888-7cd2-4776-9fd6-4cda1516ea41

Leicester, Leicestershire and Rutland Area Prescribing Committee page

## 8.1 During Normal Working Hours

For clinical microbiology advice on patients who do not have red flag sepsis please send a service request for Microbiology Clinical Advice on ICE between 09:00 and 16:00. Please provide a clear summary of the patient, the issue you wish to be addressed and your direct contact details (mobile phone or bleep number). These requests are triaged and we aim to respond within 4 working hours. Please note that requests must be made prior to 16.00 in order to facilitate a same-day response. If you need same-day Microbiology advice between 16:00 and 17:00, or urgent advice (e.g. red flag sepsis) between 09:00 and 17:00, please ring the Microbiology Doctors on **07811 024829**.

## 8.2 Out of Hours

Please contact the UHL Switchboard and ask for the “On Call Microbiology Registrar”. This will be either a Registrar or a Consultant. In most cases it would be appropriate for a clinician of similar grade to seek advice. After midnight, calls should only be made by doctors of ST3 grade and above.

Before you phone, please make sure you are aware of the patient's medical history, including details of any antibiotic therapy over the past 2 weeks and the results of any microbiological investigations (please see check list below).

**When contacting the on call medical microbiologist**, please state the following:

- Your name
- Your grade
- Your bleep or mobile number and where you are calling from
- Please also make sure you have the following information available:
  - The reason for your call
  - The patient identifiers (name, date of birth, hospital number)
  - Any recent procedures (including insertion of vascular catheters).
  - Current antibiotic regimen and previous antibiotic courses during this inpatient stay (if relevant)
  - Relevant microbiology (blood cultures, swab results, MSU results, CSF counts and culture results)
  - Any known allergies
  - Current blood results including renal function

**Please be aware that the ‘on-call’ microbiologist does not have access to laboratory results out of hours.**

**Following tests performed in Blood Sciences, please do not contact microbiology for the results. Questions regarding the interpretation of results are answered on the UHL EOLAS website;**
For web go here: https://app.eolasmedical.com/auto-login/EOLAS%23ORG%23staging-university-hospitals-of-leicester-nhs-trust%23073af352-6cdf-4b8f-bb38-defbbd40bc01%23c3ed2506-57ec-47d5-a20e-988486576deb
For mobile go here: https://app.eolasmedical.com/access-link/10af0888-7cd2-4776-9fd6-4cda1516ea41

| | |
|---|---|
| **Cyclosporin levels** | **Itraconazole levels** |
| **Tobramycin levels** | **Posaconazole levels** |
| **Vancomycin levels** | **Voriconazole levels** |

# 9 Urgent Specimens & 'Out of Hours' Specimens

- **Urgent viral Respiratory samples only (including SARS-CoV-2)** samples from GGH are tested at GGH - ring 13805 if necessary.
- **Urgent viral Respiratory samples only (including SARS-CoV-2)** samples **NOT** from GGH are tested at LRI - ring 16522 if necessary.
- Please write a bleep or extension number on request forms to allow the staff to contact you if required.
- **Mark or flag the request as 'URGENT' on the request form/electronic request.**
- For all urgent samples it is the requestor's responsibility to arrange transport of the specimen's out of hours for delivery to Clinical Microbiology Level 5 Sandringham Building LRI. Indicate on the specimen bag "For delivery to Microbiology Level 5 Sandringham"

## 9.1

Outside normal working hours, at weekends and on Public Holidays the on-call Bacteriology Biomedical Scientist (BMS) ("Microbiology Technician") **must** be contacted via the switchboard **once the specimen has been obtained**.

Out of hours examinations are offered for the following specimen types:

| Sample Type | Note |
|---|---|
| CSFs (Cerebrospinal Fluid) | Contact the on call BMS via switchboard |
| PD (Peritoneal dialysis) fluids | Not available after midnight unless approved by on call medic for microbiology. |
| Urgent surgical specimens (e.g. aspirates - joint, ascitic and pleural fluids), tissues | Joint fluids and ascitic fluids are not routinely tested after midnight. Ascitic fluids may be screened for evidence of infection (raised white cell count) using urinary dipsticks. If these are required to be processed after midnight, contact the medic on call for Microbiology. |
| Broncho-alveolar lavages | Following medical approval |
| Corneal scrapes | Following medical approval |
| Urine sample from under 3-year-olds | Contact on call BMS via switchboard if before midnight |

| | |
|---|---|
| Urine samples after midnight or from over 3-year-olds | Contact medic on call for Microbiology. via switchboard for advice regarding urgency |
| Respiratory Testing (including COVID) | Deliver sample to Microbiology |

All other sample types do not require out hour's examination.

**SHOULD YOU WISH TO DISCUSS A CLINICAL PROBLEM A MEMBER OF THE MEDICAL STAFF IS ALWAYS ON CALL.**
**Please be aware that the 'On-call BMS (Microbiology Technician)' does not have access to laboratory results out of hours. All authorised results can be viewed on ICE, Nervecentre or via GP LIMS (Laboratory Information Management System).**

# 10 Request Forms and Specimen Collection

Please keep clinical details brief and include correct antibiotic treatment.

For most routine laboratory procedures, consent will be inferred when the patient sample presents in the laboratory with a correctly filled out request form. Patient consent will be assumed when further testing is requested by telephone or a follow up request form. If the sample is from the source of a needlestick injury, consent for HIV testing will be assumed unless the request form explicitly states otherwise.

## 10.1 Add-on Tests-see individual tests for further details.

Further tests can be added verbally to specimens already in the lab, BUT the laboratory MUST be contacted and a written request, on Microbiology form or ICE/Nervecentre printout, should be forwarded to the lab as soon as possible stating the required test and recording of the name of the laboratory personnel spoken to. Following telephoned requests to add on tests, the laboratory staff can compile a request form if sufficient details are provided (see details required in section 10.2)

The time limit for requesting additional tests is at the discretion of Medical staff from Clinical Microbiology and depends on the clinical scenario discussed.

The primary microbiology samples are generally retained for 7 days. If a sample is rejected (due to no test requested, no requesting location or insufficient patient identifiers) samples will be retained for 3 days. Requests for additional testing cannot be accommodated after this time.

The time limit for additional testing on archived serum samples is 6 months, but this be extended at the discretion of the Consultant Virologist and sample availability.

## 10.2 Completion of Request Forms

**Please use electronic requesting where available.**

Personnel who have undertaken ICE training should complete the forms. However, if ICE is not available or the test you wish to request is not on the ICE, please use a manual form or phone the laboratory for further information.

**In all cases please supply the following information:**

- **Patient's Full name (Forename(s) & Surname)**
- **Hospital 'S' number (or NHS number)**
- **Date of Birth**
- **Sender's name (consultant), address and contact number (bleep number or telephone number)**
- **Date and time of collection of specimen**
- **Date of onset of symptoms, vaccination, contact etc**
- **Full clinical and epidemiological details including recent travel and case contact history**
- **Indicate tests that are required**

Please ensure that **ALL SECTIONS** are completed.
Repeatable samples will not be accepted without at least 2 patient identifiers (e.g. full name (not forename initials or nickname (e.g. Jim instead of James), date of birth and NHS or S number) or without a legible requesting location.

**Failure to clearly label the form and /or specimen with patient identifiers and sender may result in the specimen being discarded.**

See appendix 1 for examples of Virology, Bacteriology and antenatal screening form which includes infectious diseases in pregnancy (IDPS) request forms

### 10.3 Hazardous Pathogens

**Specimens which are known or suspected to contain hazardous pathogens from patients with typhoid fever, tuberculosis, HIV, hepatitis or blood cultures where patients have had foreign travel outside of Northern Europe should be labelled "HIGH RISK" or with "DANGER OF INFECTION" stickers and placed in biohazard bags.**

### 10.4 Bacteriology/Parasitology/Mycology specific instructions

Please give clinical details and indicate the antibiotics used/anticipated to enable optimum processing in the laboratory.

### 10.5 Virology/Molecular specific instructions

Please give clinical details and date of onset to enable optimum processing in the laboratory. Inadequate clinical details may result in delays and inappropriate tests being performed or delay in processing.

**Antenatal screening samples for Infectious Diseases in pregnancy (IDPS) must be sent using the specific Antenatal request form and in addition to the details required as stated above, must also include the name of the person taking the specimen. If unable to send the sample on same day store at 2-8c (see section 12.2.2 below )For antenatal screening queries not IDPS related please call 0116 204 7944. Additional details may be found on the request form in section 20 below.**

# 11 Specimen Collection - General

Specimen container **MUST** be clearly labelled with:

- **Patient's Full name (Forename (s) & Surname)**
- **Hospital 'S' number (or NHS number)**
- **Date of Birth**
- **Date and time of collection**

**These details must match those on the accompanying form, or testing will not be performed.**

Samples should be transported in the sealed section of a specimen bag. The request form must NOT be placed in the sample section of the bag and should be folded to allow the test required to be read prior to opening the sample bag. This ensures the safety protocols in place for opening the samples can be followed for the protection of the laboratory staff. Request forms with Rapid stickers for agreed rapid pathways will be tested urgently.

To enhance survival of microorganisms during transport to the laboratory, specimens should be collected in the appropriate container (see below) and should reach the laboratory as quickly as possible - overnight storage of specimens may lead to loss of some organisms and overgrowth of others.

If a delay of more than a few hours is expected, microbiology specimens should be refrigerated (except blood cultures or Quantiferon tubes - these MUST NOT be refrigerated) and sent to the laboratory as soon as possible.

It is important that all specimens are clearly labelled as most unlabelled/unidentifiable specimens are discarded.

Please ensure that lids on containers are tightened and that specimens are packaged adequately to prevent breakage during transport. Leaking specimens may be discarded. Samples should be placed in a sealable bag and accompanied with the request form.

For the safety of laboratory staff it is essential that specimens which are known or suspected to contain hazardous pathogens (e.g. patients with typhoid fever, tuberculosis, hepatitis or blood cultures where patients have had foreign travel outside of Northern Europe) should be labelled as "**HIGH RISK" or with "DANGER OF INFECTION"** stickers and placed in biohazard bags and that the "High Risk" flag is indicated on the request form. A list of hazardous pathogens and clinical conditions can be located on the 'Hazardous Pathogens and their Associated Conditions' section. Completed forms MUST NOT be placed within the same bag/pouch as the sample apart from Blood Cultures sent in a Blue bag.

## 11.1 High Risk Specimens

A High-Risk specimen is any specimen whether suspected or known to contain hazardous pathogens. Examples of hazardous pathogens include hepatitis B and C, HIV, HTLV, CJD and the causative agents of tuberculosis and typhoid fever. For a complete list refer to the Leicestershire Control of Infection Guidance.

**All blood cultures from patients with foreign travel outside Northern Europe in the preceding 3 months are considered high risk specimens.**

**Cases of suspected Viral Haemorrhagic Fever and other Hazard Group 4 infections MUST be discussed with a consultant in Infectious Diseases before collection of specimens**.

All High-Risk specimens **MUST** be transported in the sealed section of a **biohazard bag**.

The request form **MUST** be completed with full clinical information (details of foreign travel is essential), the date of onset, also indication of a high-risk flag and placed in the outer (open) pocket of the biohazard bag.

**Both the sample and request form should be labelled "High risk or with Danger of Infection" sticker**.

# 12 Specimen Transportation to Microbiology

All specimens should be correctly labelled and packaged and accompanied by a fully completed request form.

Any incidents during the transport of the specimen to the laboratory that might affect the quality of the specimen or the safety of the personnel must be reported.

For arrangements for sending urgent specimens see 'Urgent Specimens & 'Out of Hours' Specimens' section.

Refer to table 12.2.1 below for guidance on sample specific transport requirements

## 12.1 Delivery of samples

### 12.1.1 Delivery of diagnostic specimens from internal Hospital areas

It is recognised that hospital staff transporting specimens to the Pathology laboratories are usually not managed by Pathology UHL. The following systems are to be adopted by Hospital Staff; serious breaches to be reported to relevant Managers and Datix reported.

**Process to follow:**

- All specimens to be carried upright in trays and a secondary bag or in individual sealed leak proof bags. The specimens are to be in a separate pocket to request form to avoid accidental contamination of form. Known or query high risk; hazard group 3 or derogated group 3 as Advisory Committee Dangerous Pathogens (ACDP) classification should be delivered in a clearly labelled leak proof biohazard bag with request form labelled appropriately with relevant information for 'Danger of infection' biological risk. The form should also include relevant clinical details e.g. travel abroad, febrile etc.
  All specimens should be transported on/in an appropriate trolley and tray or receptacle that would contain leaks and spills. It is recommended that all trolleys used for conveyance of specimens have available spill kits, including an approved disinfectant and absorbent mopping up material.
- Leaking specimens should not leave the treatment area and should be immediately retaken.
- Specimens should be transported in such a way e.g. in a container or box, to maintain patient confidentiality.
- All specimens to be taken directly from source (or distribution route) to laboratory or laboratory specimen reception area so to be delivered in a timely manner.

- If a specimen leaks into the tray or box, report to the nearest Pathology laboratory reception for assistance if required.
- If a specimen is dropped and spilt, and if a spill kit is not readily available; it must not be touched or left unattended. Send a messenger to the nearest Pathology laboratory reception for assistance.
- Human tissue specimen containers may contain varying quantities of 4 to 10% Formalin. If spilt and not contained, contaminated areas should be cleared and if safe to do so mopped with absorbent material and then mopped up with copious water. For major spills (> 250 mls) after the area has been cleared the local Histopathology Laboratory should be called for advice and assistance as Personal Protective Equipment and Formalin spill kits may be required for clean-up.

### 12.1.2 Transportation and delivery of diagnostic specimens by road

All Diagnostic/Biological specimens transported to and from the Pathology Laboratories by road are considered to be Biological substances **Category B** status or below, this is Hazard group 3 pathogens or lower when referencing to ACDP categorisation of Pathogens.

**Category A (Hazard Group 4)** specimens are not knowingly transported and request for transportation of these would be refused and reported to Pathology Stores/ Logistics line manager or Operational /Deputy Service Manager ASAP. If driver becomes aware that they are carrying such specimens during transit then they are to report this to the Manager as stated. The specimens will be delivered to the Pathology Specimen reception, Level 2 Sandringham Building at LRI, where Notification of Viral Haemorrhagic fever or other Hazard Group 4 procedure , see section 4, will then be invoked.
*See: Risk Assessment IN 1478 Pathology Specimens Transport Service*
.

- All diagnostic specimens must be enclosed in the appropriately labelled bags and transport boxes - these must not be opened unnecessarily by the driver. The laboratory follows UN 3373 (P650 packaging instruction) as European Agreement Carriage of Dangerous Goods by Road (ADR) as regulated by Carriage of Dangerous Goods Regulations as amended.
  Essentially the packaging shall be of a good quality, strong enough to withstand the shocks and loadings normally encountered during transport and have correct UN3373 label.
  The packaging shall consist of 3 main components:
  - •A primary receptacle.
  - •A secondary packaging (sealed bag with absorbent material).
  - •A rigid secure outer package.

- Specimens to be taken directly from route completion to the appropriate laboratory reception area.

- In the event of a vehicle breakdown or accident, or incident with the conveyance; the specimens must not be touched by unauthorised personnel. Procedures for leakage and spillage are in place with spill kits available. The Pathology Stores /Transport Managers will be informed immediately.
  See *Risk Assessment IN1478 Pathology Specimens Transport Service*

### 12.1.3 Sending Samples within the LRI Site

Please use the air-tube system if you have a port in your department (see below). The air-tube port in Microbiology is number 5. Other specimens will be collected by the clinical distributor service.

When using the Air tube system:

- No glass containers
- No samples on ice
- No High-Risk samples

**NOTE: Blood cultures can be sent via the air tube**

### 12.1.4 Sending Samples from Leicester General or Glenfield Hospital Sites

During "normal working hours" Clinical Distributor staff will deliver your specimens to pathology reception. From there, hourly van services operate to the Royal Infirmary. Outside normal working hours, urgent transport is arranged by the requesting clinician.

### 12.1.5 Sending Samples from Non-UHL Sites

From Monday to Friday a daily van collection service operates between GP surgeries and Health Centres to the Royal Infirmary. Other sites will organise their own transportation arrangements.
Samples for Microbiology should be sent in the blue plastic bags provided, and purple bags for Antenatal samples.

## 12.2 Guidance on Transportation of Samples to Microbiology

### 12.2.1 Samples for Bacteriological Investigations

| Sample type | Transport requirements | Exceptions or comments |
|---|---|---|
| **Blood Cultures** | Don't fridge. Send urgently. Ideally processed within 4 hours of collection | |
| **CSF** | Send urgently, ideally to allow microscopy within 2 hours of collection. Don't fridge prior to microscopy | |
| **Faeces for PCR/Culture** | If processing is delayed, store refrigerated, rather than at room temperature (RT) | pH changes during storage (even in fridge) - may affect *Shigella* culture |
| **Faeces for CDT** | If processing is delayed, store refrigerated, rather than at room temperature (RT) | |
| **Sellotape Slides** | May be stored at RT or refrigerated for up to 48 hours before testing | |
| **Eye Samples<br>Genital Swabs<br>MRSA Screens<br>Cannulae/Tips<br>Ear Swabs<br>Mouth Swabs<br>Throat Swabs<br>LRT Samples - TB<br>CRO screen (rectal swabs)** | Test as soon as possible after collection. If processing is delayed, store refrigerated, rather than at (RT) | For *N. gonorrhoeae* culture, ideally inoculate plates at collection and incubate as soon as possible.<br>Eye samples for amoebae should be processed within 8 hours and stored at RT if delayed. |
| **Pus/Wound Swabs<br>Tissue Biopsies<br>Bile<br>Nose Swabs** | Test as soon as possible after collection. If processing is delayed, store refrigerated, rather than at (RT) | Longer transport time affects viability of anaerobic bacteria. Test bile within 3 hours of |

| Sample type | Transport requirements | Exceptions or comments |
|---|---|---|
| | | collection ideally. Larger sample size helps preserve anaerobes |
| **Fluids from Normally Sterile Sites** | Test as soon as possible after collection, within 4 hours if acute infection is suspected. If processing is delayed, store refrigerated, rather than at (RT) | |
| **Urine Samples** | Samples without Boric Acid should be processed within 4 hours or refrigerated for up to 48 hours.<br>In Boric Acid, urine may be processed up to 96 hours from collection if refrigerated. | Urine for *Schistosoma* should be tested as soon as possible after collection. If delayed, store refrigerated, rather than at (RT) |
| **Skin/Hair/Nails for superficial mycoses** | Keep sample dry and at RT | |
| **Blood Samples for QuantiFERON testing** | Samples should be kept between 22 ± 5◦C and arrive a maximum 16hrs post venepuncture. Those in LiHe should arrive within 12 hours | Do not refrigerate |
| **Blood samples for antibiotic and antifungal levels** | Samples may be sent by post. Transport time must be <7 days. Samples should be kept at 4°c if there is a delay in sending | Sample type for Isoniazid testing is whole sodium oxalate blood, is sent by post and must arrive at testing lab within 5 days of collection |
| **Samples for Galactomannan Ag** | Serum samples: Unopened samples can be stored at 2-8°C for up to 5 days prior to testing.<br>Bronchial alveolar lavages (BALs): BAL fluid samples must be uncontaminated with fungal spores and/or bacteria. Transport and store samples in sealed tubes, unexposed to air. | |

### 12.2.2 Samples for Virological investigations

| Sample type | Transport requirements | Exceptions or comments |
|---|---|---|
| **Clotted Blood for Serology Testing (including for IDPS testing)** | The centrifugation step may occur up to 24 hours post draw. Test specimens as soon as possible after collecting. Store processed specimens at 2–8°C if not tested within 24 hours of collection. Blood should be collected aseptically by venepuncture, allowed to clot, and the serum separated from the clot as soon as possible. If the assay is performed within seven days of sample collection, the samples may be kept at 2-8°C. | From Siemens Atellica kit inserts<br><br>From Diasorin Liaison XL kit inserts |
| **Whole blood (EDTA) for BBV viral load testing** | Whole blood can be stored at 2°C to 30°C and must be centrifuged within 24 hours of collection. | |
| **Swabs in Virus Transport medium for respiratory PCR, including SARS-CoV-2 PCR** | Process as soon as possible after collection, storage at 5-25ºC is acceptable. | |
| **Urine for Legionella/ Pneumococcal Ag** | Storage at RT for up to 24 hours, or refrigerated up to 1 week prior to testing | |
| **Genital swabs for STD NAAT testing** | Transport and store the specimen in the Aptima swab specimen transport tube at 2°C to 30°C for up to 60 days after collection, or in VTM at 2-8ºC for up to 3 days before testing. | |
| **Faeces for viral antigen testing (norovirus, rotavirus or adenovirus)** | Process as soon as possible after collection; store refrigerated if not being tested within 1-2 days. | |
| **BAL, ET aspirates** | Test as soon as possible after collection. If processing is delayed, store refrigerated, rather than at (RT) | |
| **Tissue biopsies** | Test as soon as possible after collection. If processing is delayed, store refrigerated, rather than at (RT) | |

A more comprehensive list of Microbiology (including Virology) samples available in section 19 'List of tests available'

## 12.3 Guidance on taking samples

Procedures associated with taking samples are based on guidelines produced by Public Health England (UKHSA) Standards for microbiology investigations (SMI). These guidelines are the minimum criteria for the taking of samples and are now available on the Royal College of Pathologists website:

https://www.rcpath.org/profession/publications/standards-for-microbiology-investigations.html

See test/sample specific pages for further details.

### 12.4 Disposal of Specimen Collection Equipment

Following collection of patient samples of all types, equipment used must be disposed of according to UHL Waste Disposal policy.

http://insite.xuhl-tr.nhs.uk/homepage/management/corporate-directorates/facilities/waster-and-recycling/waste-types

## 13 Turnaround Times (TAT)

The turnaround times quoted for the most commonly requested tests are from receipt of specimen in the laboratory to the production of the final report. These vary greatly, depending on the tests requested and whether confirmatory tests are required. Positive culture results may take longer due to antimicrobial susceptibility testing required.

The times quoted are those that are normally expected for the majority **(95%)** of our specimen workload processed during normal working days. The TAT quoted is expressed in normal working days. Tests sent to reference laboratories are marked with an asterisk (*). The turnaround times for reference laboratory tests may be longer than stated due to delays encountered at the reference laboratory or by the specimen transport system, especially over weekends or bank holiday periods. The TAT provided by the referral laboratories (from receipt to reporting) is monitored by the Microbiology Quality Team.

If you have any issues with these expected Turnaround Times, please feel free to contact the Microbiology General Manager to discuss them further.

## 14 Reference Laboratory – Referral List

All referral laboratories used are listed below, along with their UKAS accreditation status, which is checked annually.

| Reference Laboratory | UKAS Accreditation Number |
|---|---|
| Anaerobe Reference Unit, University of Wales, Cardiff | 9510 |
| Cardiff Toxicology Laboratory, Penarth | 8989 |
| CJD Unit, Western General Hospital, Edinburgh | |
| Clinical Microbiology, Queen's Medical Centre, Nottingham. | 8755 |
| Cryptosporidium Reference Laboratory, Swansea | 9510 |
| HSL (Analytics), LLP | 8059 |
| Lab21, Cambridge | 9325 |
| Leeds General Infirmary, Leeds | 8105 |
| Leeds Teaching Hospital | 8157 |

| Reference Laboratory | UKAS Accreditation Number |
|---|---|
| Leeds UKHSA Regional Laboratory | 10883 |
| Micropathology – Coventry | 9622 |
| Mycology Reference Unit – Bristol | 8043 |
| NMRS - Birmingham | 8213 |
| Source Bioscience | 9571 |
| UKHSA Birmingham, Heartlands Hospital | 8213 |
| UKHSA Bristol | 8043 |
| UKHSA Colindale | 8197 |
| UKHSA Colindale, Food Safety Microbiology Laboratory | 8197 |
| UKHSA Colindale, Lab of HealthCare Associated Infection | 8197 |
| UKHSA Colindale, Laboratory of Gastrointestinal Pathogens | 8197 |
| UKHSA Colindale, Respiratory and Systemic Infection Lab | 8197 |
| UKHSA Colindale, Sexually Transmitted Bacteria Reference Lab | 8197 |
| UKHSA Colindale, Virus Reference Department | 8825 |
| Manchester Medical Microbiology Partnership (incorporating UKHSA Meningococcal Reference Unit), Manchester | 8393 |
| UKHSA North Bristol, Southmead Hospital | 8099 |
| UKHSA West Midlands, Birmingham, Antiviral Resistance Testing Service | 8213 |
| Rare and Imported Pathogens Laboratory (RIPL), Porton Down | 9304 |
| Toxoplasma Reference Unit, Swansea | 9510 |
| University College Hospital (UKHSA National Parasitology Reference Lab), Hospital for Tropical Diseases, London | 9702 |
| Brucella reference Lab: Animal, plant and Health agency | 1769 |
| University Hospital Aintree, Liverpool | 9755 |

## 15 Quality Procedures in Place within Microbiology

Several quality procedures are in place within Microbiology which enable us to have confidence in the results which we produce and the assistance they can give in patient management.

These include:

- **Maintenance of UKAS Accreditation**
- **External Quality Assurance (EQA) schemes** - we participate in EQA from UK NEQAS, QCMD (Quality Control for Molecular Diagnostics). BMSmicro and Aurevia (among others) to provide EQA

material for all tests where suitable schemes are available. This enables us to compare the results we get for samples sent to us, with other laboratories using the same, or different platforms and methods. We also participate in sample exchange schemes with other UKAS accredited laboratories for tests where no official scheme exists.

- **Internal Quality Controls (IQC)** - these are independently sourced control material which is run with samples on various tests and is monitored to ensure it gives a result in the expected range. Patient results are not released if the IQC results are not acceptable.
- **Internal Quality Assurance (IQA)** - this is a programme of duplicate testing, whereby we re-test from 0.5-1.0% of all our samples to ensure the repeatability of the results. Any significant deviation is investigated.
- **Acceptance Testing** – this is a process for checking that new lots of reagents and kits are performing as expected. We also perform suitability checks on all suppliers (including the referral laboratories), to ensure they offer a high quality, certified or accredited service.
- **Training and Competence Monitoring** – we have an ongoing programme of competence checks for all staff and all tasks performed within the laboratory. All staff are encouraged to participate in CPD and professional grade staff maintain portfolios.
- **Audits** – all aspects of the laboratory work are audited annually and any non-conformances are investigated and suitable corrective or preventative actions are put in place.
- **Turnaround Times** - are monitored regularly to ensure reasons for any breaches are identified.
- **Incidents are recorded using Datix and are investigated thoroughly** - All non-conformances are investigated and we aim to put appropriate actions in place in a timely manner.
- **IDPS (antenatal screening) related incidents**. In addition completing non conformance and DATIX reports where appropriate the department will contact SQAS as required if issue affects patient safety.
- **IDPS (antenatal screening) results**. All positive results are e-mailed to the relevant midwifery team
- **User Feedback** - is sought annually and reviewed to enable us to address any issues raised. All complaints and concerns are investigated and responded to within timescales found in Trust guidelines.
- **Staff Suggestions** - on service or quality improvements are welcomed and all possible ways to improve the ways we work are reviewed by teams made up of a range of staff grades and implemented where they give added value.

- Molecular methods such as Polymerase chain reaction (PCR) are more sensitive than traditional microscopy and culture methods. A positive PCR/Nucleic Acid Amplification Test (NAAT) result indicates that a sample contains nucleic acid sequences specific to the target pathogen or group of pathogens. This may be from non-viable organisms present in the sample at the time of testing, residual fragments of nucleic acid from a resolved/resolving infection, or a pathogen present at a concentration lower than the detection limit of routine culture or microscopy methods. For these reasons, it is not uncommon to receive “DNA/RNA detected, culture negative” results. As with all diagnostic tests, the detection of recognised pathogens is not necessarily diagnostic of acute or ongoing disease and these results should always be correlated with clinical symptoms and response to appropriate treatment.

# 16 Antimicrobial Testing Advice

The laboratory follows the latest European Committee on Antimicrobial Susceptibility Testing (EUCAST) guidelines for both the reporting and interpretation of bacterial/fungal susceptibilities.

## 16.1 Minimum Inhibitory Concentration (MIC)

Antimicrobial susceptibility results are based on the minimum inhibitory concentration (MIC) – the lowest concentration of antimicrobial which prevents bacterial growth. The MIC of clinical isolates is often inferred from the size of the zone of inhibition on an agar plate - the area around an antimicrobial disc where the bacteria cannot grow.

The exact MIC/zone size at which a bacterial isolate is considered susceptible or resistant is known as the 'breakpoint'. The breakpoint varies considerably for each agent and organism. Breakpoints are decided by EUCAST and are based on the available pharmacokinetics and clinical outcomes data.

For many organisms the 'susceptible' breakpoint does not match the 'resistant' breakpoint. For example the Meropenem MIC susceptible breakpoint for *Acinetobacter species* is ≤2mg/L while the resistant breakpoint is >8mg/L. Organisms with a MIC which falls between the breakpoints were previously reported as 'intermediate'.

## 16.2 Interpretation of Antimicrobial Results

EUCAST guidelines on the interpretation of antimicrobial results have recently changed. In particular, this has impacted on the interpretation of 'intermediate' susceptibility.

In previous versions of the EUCAST guidelines, 'intermediate' susceptibility was defined as 'a level of antimicrobial agent activity with uncertain therapeutic effect'. However, this did not distinguish between an antimicrobial agent which would still be effective at a higher concentration, versus an agent where there is genuine uncertainty on clinical outcome. In practical terms this meant when an agent was reported as 'intermediate', it was generally avoided as a treatment option.

In the latest guidelines, EUCAST have attempted to address this issue around 'intermediate' susceptibility. The following interpretation criteria are now used by the laboratory:

| Interpretation of Antimicrobial Results (from February 2021) | | |
|---|---|---|
| Category | | Definition |
| S | Susceptible, standard dosing regimen | High likelihood of therapeutic success with the agent |
| I | Susceptible, increased exposure | Increased exposure is required for therapeutic success. 'Increased exposure' usually means an increased dose, though it can also mean increased frequency (i.e. from 3x daily to 4x daily) or altering mode of administration (i.e. prolonged or continuous infusion instead of bolus). |
| R | Resistant | High likelihood of therapeutic failure |

## 16.3 Reporting of Antimicrobial Results

Unfortunately, the in-use laboratory IT system can only currently report isolates as being 'Susceptible', 'Intermediate' or 'Resistant' - instead of 'Susceptible'(S), 'Susceptible Increased Exposure' (I)and 'Resistant'(R). Where an organism is reported as 'intermediate' to an agent, then the 'high dose' regime should be used – whilst also adjusting for renal function etc.

*To aid interpretation of results, from February 2021,* the department utilises the following standardised report comment:

*The criteria for reporting antimicrobial susceptibilities has recently changed.*

*From the end of January 2021 agents reported as 'intermediate' can still be considered effective, provided that the organism has increased exposure to the agent. Increased exposure may be achieved by either increasing the dose, frequency, or mode of administration. A further explanation can be found in the Microbiology handbook. Clinical antimicrobial advice pertaining to this should be sought from the Microbiology team as per usual instruction.*

## 16.4 Procedure to Use When Considering Using a 'Susceptible Increased Exposure' Regime

**When a higher dose regimen is needed for treatment, clinical advice from the Microbiology team should continue to be sought via the electronic referral system (or where urgent by phone). The Microbiologist will issue a code that indicates a discussion has taken place and Pharmacy will then dispense the antimicrobial agent according to that code.**

# 17 Hazardous Pathogens & their Associated Clinical Conditions

The Approved List of biological agents - HSE

The most up to date list can be found via the above link

# 18 Notifiable Diseases

The doctor who makes a clinical diagnosis of a notifiable infectious disease is responsible for the notification as a statutory duty and should contact the UKHSA's Health Protection Team (HPT) in the East Midlands. Those conditions considered **urgent** (refer to link in 18.1) should be telephoned to the HPT. For non-urgent cases, the notification form can be downloaded from https://www.gov.uk/guidance/contacts-phe-health-protection-teams#east-midlands-hpt

**East Midlands UKHSA Health Protection Team**

UK Health Security Agency
Seaton House
City Link
Nottingham
NG2 4LA
Telephone: 0344 225 4524 (option 1)

If the laboratory identifies the causative organism this is reported directly to the UKHSA.

## 18.1 Diseases Notifiable by Law under Health Protection (Notification) Regulations 2010

Current list can be accessed here;

https://www.gov.uk/guidance/notifiable-diseases-and-how-to-report-them#list-diseases

# 19 List of Tests available

Use the link below to return to the contents page, where you'll find test and sample information for all procedures performed within or referred by Clinical Microbiology. Select any test name on that page to navigate directly to its detailed information. If there is a test you cannot find in the list below or are

struggling to request, please call the laboratory on 0116 258 6508/16542/6536 for advice

Click Here to Return to the Contents Page

| Test/Sample name | **Abacavir assay** |
|---|---|
| Sample type(s) required | EDTA or Li-Hep plasma |
| Container (picture) | |
| Minimum sample volume (adult/paed if different) | 2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 4 hours. Store at 2 - 8 C if unable to transport within 4 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 14 days |
| If referred and where to and their UKAS accreditation | Referred to Cambridge Clinical Laboratories (Lab 21) - UKAS: 9325 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Drug concentration reported in ng/mL and with reference to dosing regime and required trough concentration |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment |
| Is it High Risk for sample transport if known/suspected? | Yes- patient on HIV treatment |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 24 hours |
| Contact details for queries | Virology department |

| Test/Sample name | **Acanthamoeba PCR** |
|---|---|
| Sample type(s) required | Corneal Swab, Corneal Scrape, Swab in VTM |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 1 x Dry swab in universal container or Virus Transport medium |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | Micropathology, Coventry<br>UKAS 9622 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR. All positive results phone out to clinicians |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of Acanthamoeba keratitis |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Actinomyces culture** |
|---|---|
| Sample type(s) required | Tissue. Do not send superficial swab. |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | N/A |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily Monday to Sunday. (out of hours service for urgent requests) |
| Turnaround time for 95% ? separate TRT if requested as urgent/on-call | 15 days |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant, ? reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Actinomyces species isolated (AST if available) or no growth |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of Actinomycosis. 3 main syndromes: cervico-facial, thoracic, pelvic<br><br>Not available as a standalone request on Nerve Centre. Indicate suspicion of actinomycosis on clinical details |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In-house |
| EQA scheme participated | UK NEQAS General Bacteriology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Manual culture |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Bacteriology department |

| | Adenovirus antigen (faecal) |
|---|---|
| Sample type(s) required | Faeces |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 1 day |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | Tested in panel with Rotavirus antigen |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral diarrhoea (children, immunocompromised patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | Aurevia ROAD antigens |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Manual assay (Lateral Flow device) |
| Timescale to add tests for sample types | 7 days |
| Contact details for queries | Virology department |

| Test/Sample name | **Adenovirus DNA (non-respiratory)** |
|---|---|
| Sample type(s) required | CSF, eye swabs, PM tissue |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Monday, Wednesday and Friday |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Non-respiratory viral panel comprising Herpes simplex virus (HSV) types 1 and 2, Varicella zoster virus (VZV), enterovirus, parechovirus, Cytomegalovirus (CMV), Epstein Barr virus (EBV) and Human Herpes Virus types 6 and 7 |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of CNS infection (immune-compromised patients), conjunctivitis |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD CNS I panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | PCR |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Adenovirus DNA (respiratory)** |
|---|---|
| Sample type(s) required | Respiratory Swab/Secretions, BAL, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Throat Swab or Combined Nose and Throat Swabs, Tissue |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Extended respiratory viral panel comprising Influenza virus 1 and B, Respiratory Syncytial Virus (RSV) types A and B, Parainfluenza virus types 1,2 3 and 4, adenovirus, enterovirus, rhinovirus, parechovirus, metapneumovirus types A and B, Bocavirus, Coronavirus and SARS-CoV-2 virus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral respiratory tract infection (selected group of patients -neonates, children, augmented care, immunocompromised) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Respiratory II panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | PCR |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Adenovirus DNA by PCR (quantitation)** |
|---|---|
| Sample type(s) required | EDTA blood |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 4.9mL EDTA blood (adult)<br>2.7mL EDTA blood (paed) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Micropathology, Coventry<br>UKAS 9622 |
| Link to panel when tested as part of such | |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Not detected, or quantitation in IU/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of disseminated Adenovirus infection (immunocompromised patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Alphavirus serology** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) Paediatric clotted blood 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Rare and Imported Pathogens Laboratory (RIPL), Salisbury UKAS: 9304 |
| Link to panel when tested as part of such | Usually tested as part of Viral panel selected by RIPL following relevant travel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Various IgG and IgM targets reported as detected or not detected |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of exposure/ infection with one of the genus of alphaviruses which includes chikungunya, Sindbis and Ross River viruses amongst others, if appropriate travel history present. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Amikacin level** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 0.1mL serum |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 1 day |
| If referred and where to and their UKAS accreditation | Referred to Antimicrobial Reference Laboratory, Bristol<br>UKAS 8099 |
| Normal ranges, where relevant, ? reported as IU/mL etc | Expected level:<br>Once Daily<br>Pre dose <5mg/L, Post dose 40-45mg/L. BD or TDS<br>Pre <10mg/L Post 20-30mg/L |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | mg/L |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment with a pre dose sample and a post dose sample taken 1h after end of IV/IM admin. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Amoebic (Entamoeba histolytica) antibody** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) – minimum 0.5mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 10 days |
| If referred and where to and their UKAS accreditation | Referred to Clinical Parasitology, HSL Analytics LLP at Hospital for Tropical Diseases (HTD) London - UKAS: 9702 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Positive or negative |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspected amoebic liver abscess or amoebic dysentery although test may be negative early in infection and if clinically suspected, should be repeated after 2 weeks |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | ELISA |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Anti-Streptolysin O (ASO) titres** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) Paediatric clotted blood 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Weekly on Monday |
| Turnaround time for 95% | 8 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | <200 IU/mL, 200 IU/mL or >400 IU/mL Normal range is <200 IU/mL. Levels of 200IU/mL may be found in healthy patients. Levels of >=400 IU/mL are indicative of recent streptococcal infection |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Determination of anti-Streptolysin O titre. Streptolysin O is produced by Group A Streptococcus and may be present in patients with scarlet fever, endocarditis, rheumatic fever, glomerulonephritis or streptococcal sore throat. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | Aurevia ASO titres |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Latex agglutination |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Atazanavir assay** |
|---|---|
| Sample type(s) required | EDTA or Li-Hep plasma |
| Container (picture) | |
| Minimum sample volume (adult/paed if different) | 2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 4 hours. Store at 2 - 8 C if unable to transport within 4 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 14 days |
| If referred and where to and their UKAS accreditation | Referred to Cambridge Clinical Laboratories (Lab 21) - UKAS: 9325 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Drug concentration reported in ng/mL and with reference to dosing regime and required trough concentration |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment |
| Is it High Risk for sample transport if known/suspected? | Yes – patient on HIV treatment |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 24 hours |
| Contact details for queries | Virology department |

| Test/Sample name | **Beta Glucan** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Ambient temperature for transport. Unopened samples can be 2-8° C storage. |
| Testing frequency | Daily, Monday to Friday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 working days |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant, reported as IU/mL etc | <60 pg/mL – Negative<br>60-79 pg/mL – Equivocal<br>≥80 pg/mL - Positive |
| Link to panel when tested as part of such | N/A<br>May be tested with Galactomannan antigen |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of invasive candidiasis. Other invasive fungal infections may also give a positive result |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | Sample exchange |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | EIA |
| Timescale to add tests for sample types | 6 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Blood culture** |
|---|---|
| Sample type(s) required | **Adult:** BacT/Alert® SA and BacT/Alert ® SN<br>**Paediatric:** BacT/Alert ® PF Plus |
| Container (picture) |  |
| Minimum sample volume (Adults only) | 10 mL in each bottle (5-12mL acceptable range) |
| Pre-analytics storage/transport | Don't refrigerate. Send urgently. Ideally processed within 4 hours of collection |
| Testing frequency | 24/7 |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant, ? reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | The following results are telephoned to clinicians by the Microbiology Medics:<br>• Potentially significant blood culture Gram stain results<br>• Significant positive blood culture isolate results if they require a change in patient management or further microbiology input |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of sepsis |
| Is it High Risk for sample transport if known/suspected? | Dependant on travel history and organism suspected. |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | BMS Micro Blood culture scheme |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Automated microbial detection system and manual culture |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Bocavirus DNA** |
|---|---|
| Sample type(s) required | Respiratory Swab/Secretions, BAL, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Throat Swab or Combined Nose and Throat Swabs, Tissue |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Extended respiratory viral panel comprising Influenza virus 1 and B, Respiratory Syncytial Virus (RSV) types A and B, Parainfluenza virus types 1,2 3 and 4, adenovirus, enterovirus, rhinovirus, parechovirus, metapneumovirus types A and B, Bocavirus, Coronavirus and SARS-CoV-2 virus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral respiratory tract infection (selected group of patients -neonates, children, augmented care, immunocompromised) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | Sample exchange with Micropathology and Blackpool |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Bordetella pertussis serology** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL)<br>Paediatric clotted blood 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 14 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Colindale<br>UKAS: 8197 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | IU/mL = International units of B.pertussis anti-pertussis toxin (PT) IgG.<br>IN THE ABSENCE OF RECENT VACCINATION >70 IU/mL = consistent with recent infection |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of recent infection with Bordetella pertussis (Pertussis/ Whooping cough) or measure antibody response after vaccination against Pertussis |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Bordetella spp. DNA** |
|---|---|
| Sample type(s) required | BAL, Sputum, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Nasopharyngeal Swabs (inc. Pernasal Swabs), Nose/Throat Swabs |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | 2-3 times per week |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Pneumonia PCR panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Clinical suspicion of whooping cough |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Respiratory III panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

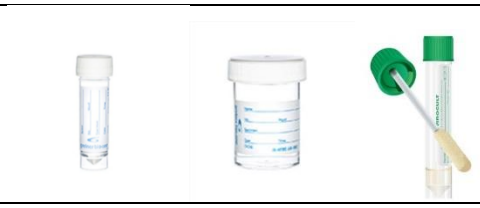
| Test/Sample name | **Borrelia burgdorferi IgG** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected (with interpretive comments where appropriate) |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of infection with Borrelia burgdorferi (Lyme Disease) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Referred to Rare and Imported Pathogens Laboratory, Salisbury |
| EQA scheme participated | Aurevia Borrelia burgdorferi serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

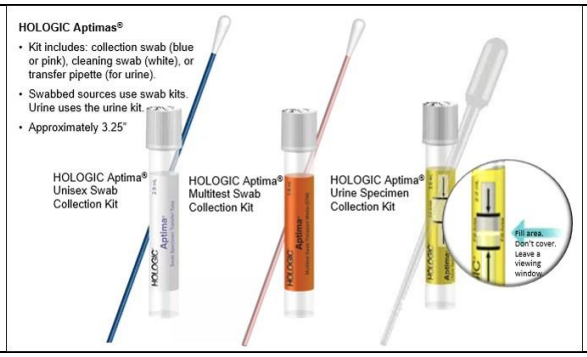
| Test/Sample name | **Brucella serology** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL)<br>Paediatric clotted blood 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 9 days |
| If referred and where to and their UKAS accreditation | Referred to Brucella Reference Unit, Liverpool<br>UKAS: 9756 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | All positives phoned out |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Evidence of exposure to Brucella. Risk factors- travel history to endemic countries, consuming unpasteurised dairy products, contact with farm animals |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Burkholderia cepacia culture** |
|---|---|
| Sample type(s) required | Sputum, BAL, ET aspirate, cough swab |
| Container (picture) | CE marked leak proof Sterile Container |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Process as soon as possible after collection, storage at 2-8C |
| Testing frequency | Daily |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 6 days |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant, reported as IU/mL etc | |
| Link to panel when tested as part of such | |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Isolated or Not isolated<br><br>If isolated = Medical decision if phoned out |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of respiratory tract infection by Burkholderia cepacia (only CF (Cystic Fibrosis) /PCD (Primary Ciliary Dyskinesia) patients) |
| Is it High Risk for sample transport if known/suspected? | |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS general bacteriology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Culture |
| Timescale to add tests for sample types | 7 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Campylobacter spp** |
|---|---|
| Sample type(s) required | Faeces - Faecal sample container with spoon (Blue cap). |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 5 mL |
| Pre-analytics storage/transport | Within 24 hours if stored at ambient temperature. Within 5 days if stored at 2-8°C |
| Testing frequency | Daily |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | N/A |
| Link to panel when tested as part of such | Enteric PCR panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by PCR or Not detected by PCR Samples may be reported as invalid if repeat testing fails to generate a result. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | This assay is intended for use with liquid/loose stool samples, types 5-7 on the Bristol Stool Chart. Formed stool samples, types 1-4 are reported stating that the sensitivity of the assay may be reduced, and results should be interpreted with caution. No testing within 7 days of a previous sample. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In-house culture methods may be used to confirm or speciate positive results. These have a separate TRT |
| EQA scheme participated | UK NEQAS General Bacteriology (Campylobacter, Salmonella, Shigella, Vibrio & Yersinia), QCMD Bacterial gastroenteritis (Salmonella, Shigella, Yersinia, E. coli O157, Campylobacter) |
| Is test UKAS accredited (refer to sample types if necessary) | Accredited |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | 5 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Chlamydia pneumoniae DNA** |
|---|---|
| Sample type(s) required | BAL, Sputum, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Nasopharyngeal Swabs (inc. Pernasal Swabs), Nose/Throat Swabs |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | N/A |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | 2-3 times per week |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | Pneumonia PCR panel comprising<br>Staph. aureus, Strep. pneumoniae, M. pneumoniae, Chlamydia pneumoniae, Chl. psittaci, Legionella pneumophila, Legionella longbeachae, Haemphilus spp, Pneumocystis jirovecii, Mycobacterium tuberculosis, Cryptococcus spp, Bordetella spp, Coxiella burnetii, and Aspergillus fumigatus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors | Suspicion of pneumonia caused by atypical bacterial pathogens |
| Is it High Risk for sample transport if known/ suspected? | N/A |
| Is confirmation testing in-house or referred | N/A |
| EQA scheme participated | QCMD Ch. pneumoniae |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |
| | |

| Test/Sample name | **Chlamydia psittaci DNA** |
|---|---|
| Sample type(s) required | BAL, Sputum, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA) or swab, Pernasal Swabs, Nose/Throat Swabs |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | N/A |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours or store at 2 - 8 C. |
| Testing frequency | 2-3 times per week |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | Pneumonia PCR panel comprising<br>Staph. aureus, Strep. pneumoniae, M. pneumoniae, Chlamydia pneumoniae, Chl. psittaci, Legionella pneumophila, Legionella longbeachae, Haemphilus spp, Pneumocystis jirovecii, Mycobacterium tuberculosis, Cryptococcus spp, Bordetella spp, Coxiella burnetii, and Aspergillus fumigatus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of pneumonia caused by atypical bacterial pathogens |
| Is it High Risk for sample transport if known/suspected? | N/A |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Ch. psittaci |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Chlamydia trachomatis DNA** |
|---|---|
| Sample type(s) required | Urine, Genital Swab, Rectal swab, Eye swab, Throat Swab |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | 3 times a week |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Chlamydia trachomatis and Neisseria gonorrhoeae NAAT testing performed as panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as detected or not detected by NAATs.<br>Positive eye swabs or samples from pregnant patients phoned out |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of Chlamydia trachomatis infection (STI). This test can also be requested on eye samples from a neonate if ophthalmia neonatorum is suspected. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD STD II panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **CJD, vCJD (Creutzfeldt-Jakob Disease)** |
|---|---|
| Sample type(s) required | CSF |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 5mL |
| Pre-analytics storage/transport | If not processed quickly, store at 2-8 C until ready for processing |
| Testing frequency | As required |
| Turnaround time for 95% | 4 days |
| If referred and where to and their UKAS accreditation | Edinburgh - Due to the highly specialised nature of the work they undertake they have not been formally accredited. |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of vCJD |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | PCR panel – specific required target reported |
| Timescale to add tests for sample types | 7 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Clostridium difficile toxin testing** |
|---|---|
| Sample type(s) required | Faeces - Faecal sample container with spoon (Blue cap). |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 5mL required for full enteric screen |
| Pre-analytics storage/transport | If not processed quickly store at 2-8°C until ready for processing |
| Testing frequency | Daily |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | Next day |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant, reported as IU/mL etc | C. difficile screen for GDH: Positive = >1.0 COI; C. difficile screen for toxin A/B: Positive = >1.0 COI ; CD PCR positive |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | C. difficile detected or not detected. Micro. medics to contact IP team and clinician for in-patients |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of C.difficile diarrhoea. Not appropriate for anyone under the age of 2, or if patient has already tested positive in the last 28 days. Do not re-test within 3 days of testing. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In-house |
| EQA scheme participated | UKNEQAS C difficile |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | EIA and Molecular |
| Timescale to add tests for sample types | 7 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **CMV IgG avidity** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | Only tested when required based on CMV IgM and IgG results, usually in pregnant patients |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected with interpretive comments, if appropriate |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Assessment of how recent past CMV infection was, especially during pregnancy |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS CMV detection |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **CMV IgG** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected, equivocal or not detected with interpretive comments, if appropriate |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of past Cytomegalovirus (CMV) infection. May indicate risk of reactivation in immune-suppressed or immune compromised patients. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS CMV detection |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **CMV IgM** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected with interpretive comments, if appropriate |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of acute/recent CMV infection. However, antibody may also be detected during reactivation.<br>Often associated with glandular fever or abnormal LFTs. Risks of serious foetal damage from primary infection during pregnancy |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS CMV detection |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Coxiella burnetii IgM** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL)<br>Paediatric clotted blood 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 10 days |
| If referred and where to and their UKAS accreditation | Referred to Rare and Imported Pathogen Laboratory, Salisbury<br>UKAS: 9304 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | All positives phoned out |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of acute/recent infection with Coxiella burnetii (Q-fever). Some of the clinical scenarios include PUO, atypical pneumonia or endocarditis |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Cryptococcal antigen** |
|---|---|
| Sample type(s) required | Serum, CSF |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) Paediatric clotted blood 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 1 day |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Positive or negative |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of disseminated Cryptococcus infection (immunocompromised patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Positives referred for confirmation and titration to Mycology Reference Laboratory, Bristol |
| EQA scheme participated | UK NEQAS Cryptococcal antigen detection |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Lateral flow device |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Cryptosporidium spp** |
|---|---|
| Sample type(s) required | Faeces - Faecal sample container with spoon (Blue cap). |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 5 mL |
| Pre-analytics storage/transport | Within 24 hours if stored at ambient temperature. Within 5 days if stored at 2-8°C |
| Testing frequency | Daily |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | In house testing; positives referred to UKHSA Swansea UKAS: 9510 |
| Link to panel when tested as part of such | Enteric PCR panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by PCR or Not detected by PCR Samples may be reported as invalid if repeat testing fails to generate a result. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | This assay is intended for use with liquid/loose stool samples, types 5-7 on the Bristol Stool Chart. Formed stool samples, types 1-4 are reported stating that the sensitivity of the assay may be reduced, and results should be interpreted with caution |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Parasitic gastroenteritis (Cryptosporidium, Giardia, Entamoeba) |
| Is test UKAS accredited (refer to sample types if necessary) | Accredited |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | 5 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Cycloserine level** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 0.1mL serum |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Antimicrobial Reference Laboratory, Bristol<br>UKAS 8099 |
| Normal ranges, where relevant, ? reported as IU/mL etc | Expected level:<br>Pre dose 10-20 mg/L<br>Post dose (3-4h) 20-35 mg/L<br>Levels to be kept below 35 mg/L |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | mg/L |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment with a pre dose sample and a post dose sample, taken 3-4 hours after oral administration |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Cysticercosis (Taenia) antibody** |
|---|---|
| Sample type(s) required | Serum or CSF |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) – minimum 0.5mL serum 0.2mL CSF |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 10 days |
| If referred and where to and their UKAS accreditation | Referred to Clinical Parasitology, HSL Analytics LLP at Hospital for Tropical Diseases (HTD) London - UKAS: 9702 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of cysticercosis caused by Taenia solium (tapeworm) egg ingestion. Not useful for intestinal infection. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Immunoblotting.<br>Antigen test also available. |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Cytomegalovirus (CMV) DNA by PCR (referred)** |
|---|---|
| Sample type(s) required | Tissue biopsy in sterile container |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection.<br>Samples in formalin are unsuitable for PCR testing |
| Testing frequency | As required |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Micropathology<br>UKAS: 9622 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Disseminated CMV infection including colonic infection (immunocompromised patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Cytomegalovirus (CMV) DNA quantitation by PCR** |
|---|---|
| Sample type(s) required | Whole EDTA blood |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 4.9mL EDTA blood |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Twice weekly |
| Turnaround time for 95% | 6 days |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | IU/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Disseminated CMV infection (immunocompromised patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD CMV DNA quantitation |
| Is test UKAS accredited (refer to sample types if necessary) | No (pending) |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Cytomegalovirus (CMV) DNA** |
|---|---|
| Sample type(s) required | CSF, Nasopharyngeal aspirate (NPA), Skin, Throat, nose, mouth, & eye swabs |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Monday, Wednesday and Friday |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Non-respiratory viral panel comprising Herpes simplex virus (HSV) types 1 and 2, Varicella zoster virus (VZV), enterovirus, parechovirus, Cytomegalovirus (CMV), Epstein Barr virus (EBV) and Human Herpes Virus types 6 and 7 |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of CNS infection (immune-compromised patients) or congenital CMV infection |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD TRANS panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Daptomycin assay** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 0.1 mL serum |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Antimicrobial Reference Laboratory, Bristol<br>UKAS 8099 |
| Normal ranges, where relevant, reported as IU/mL etc | Expected level<br>(6 - 8mg/kg dose):<br>Pre dose 5-25 mg/L or Pre dose 10-25mg/L in severe sepsis or deep-seated infection.<br>Pre dose levels >24.3mg/L associated with increased risk of toxicity. |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | mg/L |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment with a pre dose sample and a post dose sample, taken 1 hour after the end of iv administration |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Darunavir assay** |
|---|---|
| Sample type(s) required | EDTA or Li-Hep plasma |
| Container (picture) | |
| Minimum sample volume (adult/paed if different) | 2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 4 hours. Store at 2 - 8 C if unable to transport within 4 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 14 days |
| If referred and where to and their UKAS accreditation | Referred to Cambridge Clinical Laboratories (Lab 21) - UKAS: 9325 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Drug concentration reported in ng/mL and with reference to dosing regime and required trough concentration |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment |
| Is it High Risk for sample transport if known/suspected? | Yes – patient on HIV treatment |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 24 hours |
| Contact details for queries | Virology department |

| Test/Sample name | **Dengue serology** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL)<br>Paediatric clotted blood 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 7 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Rare and Imported Pathogens Laboratory (RIPL), Salisbury<br>UKAS: 9304 |
| Link to panel when tested as part of such | Usually tested as part of Viral panel selected by RIPL following relevant travel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Dengue IgG and IgM reported as detected or not detected by EIA.<br>When appropriate Dengue virus RNA may also be tested and reported as detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of dengue virus infection (Dengue Fever) |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Dialysis catheter screen** |
|---|---|
| Sample type(s) required | Gel Amies plain swab (Blue cap) |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily Monday to Friday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 4 working days |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of skin colonisation by MSSA/MRSA |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In-house |
| EQA scheme participated | UK NEQAS General Bacteriology |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | Manual culture |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Diphtheria neutralisation test** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL)<br>Paediatric clotted blood 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 21 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Colindale<br>UKAS: 8197 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Antitoxin levels reported as IU/mL with interpretive comments regarding level of protection provided |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Measure antibody response after vaccination against diphtheria |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Direct CRO screening for IMP1, VIM, NDM, KPC, OXA48 genes** |
|---|---|
| Sample type(s) required | Rectal swab – Red cap dual swab in Stuart media. |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | N/A |
| Pre-analytics storage/transport | If not processed quickly store at 2-28°C until ready for processing. |
| Testing frequency | Daily |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 1 day |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected for each target. Microbiology medics contact clinicians if any target gene is detected for the first time in an inpatient (only when Infection Prevention and Control team isn't available). |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for gut colonisation with Extensively Drug Resistant (XDR) bacteria in patients if one or more of the listed criteria is/are met- UK Inter-hospital transfer, recent hospital admission (including UHL) in the past 12 months, history of hospitalisation or received healthcare outside UK |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD ESBL |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Discharge culture** |
|---|---|
| Sample type(s) required | High vaginal swab, Lower vaginal swab, Endocervical swab (for Neisseria gonorrhoeae) |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | N/A |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily. Monday to Friday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of vulvo-vaginal candidiasis, Gardnerella or Trichomonas infection. HVS are not suitable for the isolation of N. gonorrhoeae (endocervical swabs should be submitted instead) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In-house |
| Factors known to affect result | |
| EQA scheme participated | UK NEQAS Genital Pathogens, BMSMicro Trichomonas, and BMSMicro BV and Candida |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Manual culture |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Dolutegravir assay** |
|---|---|
| Sample type(s) required | EDTA or Li-Hep plasma |
| Container (picture) | |
| Minimum sample volume (adult/paed if different) | 2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 4 hours. Store at 2 - 8 C if unable to transport within 4 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 14 days |
| If referred and where to and their UKAS accreditation | Referred to Cambridge Clinical Laboratories (Lab 21) - UKAS: 9325 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Drug concentration reported in ng/mL and with reference to dosing regime and required trough concentration |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment |
| Is it High Risk for sample transport if known/suspected? | Yes – patient on HIV treatment |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 24 hours |
| Contact details for queries | Virology department |

| Test/Sample name | **Doravirine assay** |
|---|---|
| Sample type(s) required | EDTA or Li-Hep plasma |
| Container (picture) | |
| Minimum sample volume (adult/paed if different) | 2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 4 hours. Store at 2 - 8 C if unable to transport within 4 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 14 days |
| If referred and where to and their UKAS accreditation | Referred to Cambridge Clinical Laboratories (Lab 21) - UKAS: 9325 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Drug concentration reported in ng/mL and with reference to dosing regime and required trough concentration |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment |
| Is it High Risk for sample transport if known/suspected? | Yes- patient on HIV treatment |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 24 hours |
| Contact details for queries | Virology department |

| Test/Sample name | **EBV (Epstein Barr Virus) EBNA IgG** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A – added to assist interpretation of unusual EBV VCA IgM and IgG results |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected, equivocal or not detected with interpretive comments, if appropriate |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Presence indicative of resolved EBV infection |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS EBV detection |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **EBV (Epstein Barr Virus) VCA IgG** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, ?reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected, equivocal or not detected with interpretive comments, if appropriate |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of past infection with EBV. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS EBV detection |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

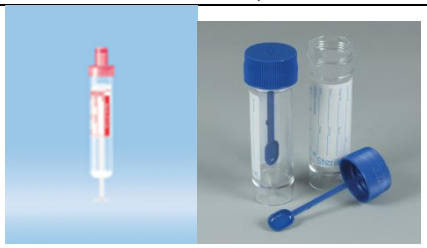
| Test/Sample name | **EBV (Epstein Barr Virus) VCA IgM** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | Usually tested with EBV VCA IgG |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected with interpretive comments, if appropriate |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check with evidence of acute/recent infection with EBV. Most often associated with glandular fever. However, antibody may also be detected during reactivation. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS EBV detection |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Emtricitabine assay** |
|---|---|
| Sample type(s) required | EDTA or Li-Hep plasma |
| Container (picture) | |
| Minimum sample volume (adult/paed if different) | 2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 4 hours. Store at 2 - 8 C if unable to transport within 4 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 14 days |
| If referred and where to and their UKAS accreditation | Referred to Cambridge Clinical Laboratories (Lab 21) - UKAS: 9325 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Drug concentration reported in ng/mL and with reference to dosing regime and required trough concentration |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment |
| Is it High Risk for sample transport if known/suspected? | Yes- patient on HIV treatment |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 24 hours |
| Contact details for queries | Virology department |

| Test/Sample name | **Entamoeba histolytica** |
|---|---|
| Sample type(s) required | Faeces - Faecal sample container with spoon (Blue cap). |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 5 mL |
| Pre-analytics storage/transport | Within 24 hours if stored at ambient temperature. Within 5 days if stored at 2-8°C |
| Testing frequency | Daily |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | N/A |
| Link to panel when tested as part of such | Enteric PCR panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by PCR or Not detected by PCR. Samples may be reported as invalid if repeat testing fails to generate a result. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | This assay is intended for use with liquid/loose stool samples, types 5-7 on the Bristol Stool Chart. Formed stool samples, types 1-4 are reported stating that the sensitivity of the assay may be reduced, and results should be interpreted with caution. No testing within 7 days of a previous sample. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Parasitic gastroenteritis (Cryptosporidium, Giardia, Entamoeba) |
| Is test UKAS accredited (refer to sample types if necessary) | Accredited |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | 5 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Enterovirus RNA (non-respiratory)** |
|---|---|
| Sample type(s) required | CSF, Skin swabs |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Monday, Wednesday and Friday |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | Tested in house. |
| Link to panel when tested as part of such | Non-respiratory viral panel comprising Herpes simplex virus (HSV) types 1 and 2, Varicella zoster virus (VZV), enterovirus, parechovirus, Cytomegalovirus (CMV), Epstein Barr virus (EBV) and Human Herpes Virus types 6 and 7 |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Test CSF if viral meningitis is suspected. Skin swabs can be tested if an exanthem is present. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Positive samples referred for further typing/characterisation to UKHSA Colindale, UKAS number 8825 |
| EQA scheme participated | QCMD CNS1 panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Enterovirus RNA (respiratory)** |
|---|---|
| Sample type(s) required | Respiratory Swab/Secretions, BAL, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Throat Swab or Combined Nose and Throat Swabs, Tissue |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Extended respiratory viral panel comprising Influenza virus 1 and B, Respiratory Syncytial Virus (RSV) types A and B, Parainfluenza virus types 1,2 3 and 4, adenovirus, enterovirus, rhinovirus, parechovirus, metapneumovirus types A and B, Bocavirus, Coronavirus and SARS-CoV-2 virus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral respiratory tract infection (selected group of patients -neonates, children, augmented care, immunocompromised) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Positive samples may be referred for further typing/characterisation to UKHSA Colindale, UKAS reference 8825 |
| EQA scheme participated | QCMD Respiratory II panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Enterovirus RNA by PCR (referred)** |
|---|---|
| Sample type(s) required | Whole EDTA blood, Faeces |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 4.9mL EDTA blood or 1mL faeces |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily/as required |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Micropathology<br>UKAS: 9622 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as Not detected, or if detected, as copies/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of disseminated Enteroviral infection (immunocompromised patients or children) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |
| Date details reviewed/due for review | August 2025 |

| Test/Sample name | **Epstein Barr Virus (EBV) DNA quantitation by PCR** |
|---|---|
| Sample type(s) required | Whole EDTA blood |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 5ml |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Twice weekly |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | IU/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Disseminated EBV infection (immunocompromised patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD EBV DNA quantitation |
| Is test UKAS accredited (refer to sample types if necessary) | No (pending) |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Epstein Barr Virus (EBV) DNA** |
|---|---|
| Sample type(s) required | CSF, Skin, Throat, nose, mouth, & eye swabs |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Patient prep required for taking sample. Are any patient taken samples? Is info provided? | N/A |
| Testing frequency | Monday, Wednesday and Friday |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | N/A |
| Link to panel when tested as part of such | Non-respiratory viral panel comprising Herpes simplex virus (HSV) types 1 and 2, Varicella zoster virus (VZV), enterovirus, parechovirus, Cytomegalovirus (CMV), Epstein Barr virus (EBV) and Human Herpes Virus types 6 and 7 |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of CNS infection (immunocompromised patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD TRANS panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Ethambutol level** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 0.1mL serum |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Antimicrobial Reference Laboratory, Bristol<br>UKAS 8099 |
| Normal ranges, where relevant, reported as IU/mL etc | Expected level:<br>Pre dose: <1 mg/L<br>Post dose: 2 – 6 mg/L |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | mg/L |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment with a pre dose sample taken up to an hour before dosing and a post dose sample taken 2 hours after oral administration |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Fasciola antibody** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) – minimum 0.5mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 10 days |
| If referred and where to and their UKAS accreditation | Referred to Clinical Parasitology, HSL Analytics LLP at Hospital for Tropical Diseases (HTD) London - UKAS: 9702 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Titre; >128 considered positive |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of fasciola infection (liver fluke parasite). Patients with upper abdominal pain, thought to be hepatic, eosinophilia and fever, should be investigated |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | IFAT (immunofluorescence Antibody test) |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Filaria antibody** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) – minimum 0.5mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 10 days |
| If referred and where to and their UKAS accreditation | Referred to Clinical Parasitology, HSL Analytics LLP at Hospital for Tropical Diseases (HTD) London - UKAS: 9702 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Positive results are reported at Levels 1 to 9. Levels 1 and 2 are regarded as weak positives; Levels 5 and over are strong positives |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of filaria infection. Infection may be linked with eosinophilia. Most useful in the diagnosis of TPE (Tropical Pulmonary Eosinophilia) where high antifilarial antibody levels are required to make the diagnosis. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | ELISA |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Flucytosine level** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 0.1mL serum |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 2 days |
| If referred and where to and their UKAS accreditation | Referred to Antimicrobial Reference Laboratory, Bristol<br>UKAS 8099 |
| Normal ranges, where relevant, reported as IU/mL etc | Aim for peak serum concentrations of 50-100 mg/L and trough of 20-40 mg/L/ Levels >100 mg/L are toxic |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | mg/L |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Fungal culture** |
|---|---|
| Sample type(s) required | Skin, nail, hair, CSF, sputum/BAL in a sterile container. The first 3 sample types can be sent in a commercially available paper or brush too. |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | N/A |
| Pre-analytics storage/transport | Patient's skin should be swabbed with 70% alcohol. Lesions should be scraped with a blunt scalpel blade.<br>Specify if fingernails or toenails. Material should be taken from any discoloured, dystrophic or brittle parts of the nail.<br>Scalp samples should include skin scales and plucked hairs.<br>Store/transport at room temperature |
| Testing frequency | As required |
| Turnaround time for 95% | 14-21 days |
| If referred and where to and their UKAS accreditation | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | N/A |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Current testing algorithm (microscopy and culture):-<br>• All skin and hair specimens<br>• All samples from secondary care<br>• All specimens from children (aged =<18yrs)<br>Nail specimens from primary care would be processed in case of:<br>• Empirical treatment failure<br>• Infection arising after foreign travel<br>• Unusual animal or environmental exposure<br>• Immunosuppressed<br>• Diabetes<br>• Requests approved by named Microbiologist |
| Is it High Risk for sample transport if known/suspected? | Samples from patients with known or suspected Blastomyces dermatitidis, Coccidioides spp, Histoplasma capsulatum, Paracoccidioides brasiliensis, Cladophialophora bantiana or Talaromyces marneffei (formerly Penicillium marneffei) should be marked as High Risk |
| Is confirmation testing in-house (included in TRT?) or referred | Separate TRT for positive samples referred for further identification |

| | |
|---|---|
| EQA scheme participated | UK NEQAS Mycology scheme |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Culture |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Bacteriology department |
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|---|---|
| **Test/Sample name** | **Fungal microscopy** |
| Sample type(s) required | Skin, nail, hair, CSF, sputum/BAL in a sterile container. The first 3 sample types can be sent in a commercially available paper or brush too. |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | N/A |
| Pre-analytics storage/transport | Patient's skin should be swabbed with 70% alcohol. Lesions should be scraped with a blunt scalpel blade.<br>Specify if fingernails or toenails. Material should be taken from any discoloured, dystrophic or brittle parts of the nail.<br>Scalp samples should include skin scales and plucked hairs.<br>Store/transport at room temperature |
| Testing frequency | As required |
| Turnaround time for 95% | 7-10 days |
| If referred and where to and their UKAS accreditation | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | N/A |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Current testing algorithm (microscopy and culture):-<br>• All skin and hair specimens<br>• All samples from secondary care<br>• All specimens from children (aged =<18yrs)<br>Nail specimens from primary care would be processed in case of:<br>• Empirical treatment failure<br>• Infection arising after foreign travel<br>• Unusual animal or environmental exposure<br>• Immunosuppressed<br>• Diabetes<br>• Requests approved by named Microbiologist |
| Is it High Risk for sample transport if known/suspected? | Samples from patients with known or suspected Blastomyces dermatitidis, Coccidioides spp, Histoplasma capsulatum, Paracoccidioides brasiliensis, Cladophialophora bantiana or Talaromyces marneffei (formerly Penicillium marneffei) should be marked as High Risk |

| | |
|---|---|
| Is confirmation testing in-house (included in TRT?) or referred | Separate TRT for positive samples referred for further identification |
| EQA scheme participated | UK NEQAS Mycology scheme |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Microscopy using variety of staining methods |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Galactomannan antigen** |
|---|---|
| Sample type(s) required | Serum or Bronchoalveolar Lavage (BAL) |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Serum samples: Unopened samples can be stored at 2-8°C for up to 5 days prior to testing. Bronchoalveolar lavages (BALs): BAL fluid samples must be uncontaminated with fungal spores and/or bacteria. Transport and store samples in sealed tubes, unexposed to air. |
| Testing frequency | Daily (Monday to Friday) |
| Turnaround time for 95% | 7 days |
| If referred and where to and their UKAS accreditation | In house |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspected Invasive Aspergillosis (mostly immunocompromised and/or neutropaenic patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In-house |
| EQA scheme participated | UK NEQAS Fungal biomarkers |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Enzyme Immunoassay |
| Timescale to add tests for sample types | 6 months |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Giardia lamblia** |
|---|---|
| Sample type(s) required | Faeces - Faecal sample container with spoon (Blue cap). |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 5 mL |
| Pre-analytics storage/transport | Within 24 hours if stored at ambient temperature. Within 5 days if stored at 2-8°C |
| Testing frequency | Daily |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | N/A |
| Link to panel when tested as part of such | Enteric PCR panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by PCR or Not detected by PCR. Samples may be reported as invalid if repeat testing fails to generate a result. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | This assay is intended for use with liquid/loose stool samples, types 5-7 on the Bristol Stool Chart. Formed stool samples, types 1-4 are reported stating that the sensitivity of the assay may be reduced, and results should be interpreted with caution. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Parasitic gastroenteritis (Cryptosporidium, Giardia, Entamoeba) |
| Is test UKAS accredited (refer to sample types if necessary) | Accredited |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | 5 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Helicobacter pylori serology** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL)<br>Paediatric clotted blood 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | |
| If referred and where to and their UKAS accreditation | Referred to Queen's Medical Centre, Nottingham<br>UKAS: 8755 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | IgG Detected or Not detected |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of past H.pylori infection.<br>Not suitable for test of cure or evidence of current/acute infection. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis A (HAV) Total antibody** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL). Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 2 days |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant, ?reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA, Equivocal by EIA or Not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of Hepatitis A infection in the past.<br>Assay detects all antibodies, so HAV IgM needed to determine whether infection is acute. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS HAV detection |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence assay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis A IgM (HAV IgM)** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL). Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 2 days |
| If referred and where to and their UKAS accreditation | Positives referred to UKHSA Colindale for sero-typing and epidemiological follow-up - UKAS: 8825 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA or Not detected by EIA. All positives telephoned out by Virology medical staff. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of acute/recent Hepatitis A (HAV) infection. Can be tested as part of investigation for raised ALT. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS HAV detection |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence assay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis B (HBV) resistance testing** |
|---|---|
| Sample type(s) required | Whole EDTA blood, Serum |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 28 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Colindale<br>UKAS: 8825 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Drug resistance sequences reported |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Resistance to anti-HBV drugs |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis B core Antibody (HBcAb)** |
|---|---|
| Sample type(s) required | Serum, including Infectious Diseases in Pregnancy screening (IDPS), plasma |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA or Not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Used to provide evidence of past or current HBV infection - this may indicate potential for reactivation in immunocompromised or immune-suppressed patients. Usually tested in conjunction with HBsAg. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In-house, included in TRT |
| EQA scheme participated | UK NEQAS HBV serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence assay and confirmed on alternative chemiluminescence assay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis B Core IgM** |
|---|---|
| Sample type(s) required | Serum, including Infectious Diseases in Pregnancy screening (IDPS), plasma |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA or Not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Added in-house when samples are HBsAg positive for the first time to assess whether infection is acute or chronic. HBc IgM positive in acute/recent infection |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS HBV serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence assay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

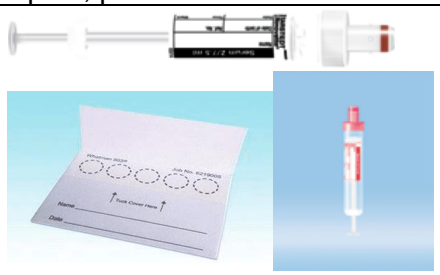
| Test/Sample name | **Hepatitis B DNA quantitative PCR (HBV DNA)** |
|---|---|
| Sample type(s) required | Serum, plasma (Serum preferred) |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Serum/plasma samples must be received in the lab within 6 hours of collection. |
| Testing frequency | Twice weekly |
| Turnaround time for 95% | 15 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by PCR or Not detected by PCR. Positive results are reported as IU/mL and log IU/mL. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Determination of HBV viral load. Used to confirm current infection and to monitor response to treatment.<br>Only suitable for known HBsAg positive patients or to assess possible reactivation in known previously HBsAg positive patients. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS HBV DNA quantitation |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | 6 months, but this be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |
| | |

| Test/Sample name | **Hepatitis B e Antibody (HBeAb)** |
|---|---|
| Sample type(s) required | Serum, including Infectious Diseases in Pregnancy screening (IDPS), plasma |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA or Not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Added in-house to new and known HBsAg positive patient samples to assess infectivity (especially in pregnancy). HBeAb positive indicates low infectivity. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS HBV serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence assay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis B e Antigen (HBeAg)** |
|---|---|
| Sample type(s) required | Serum, including Infectious Diseases in Pregnancy screening (IDPS), plasma |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA or Not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Added in-house to new and known HBsAg positive patient samples to assess infectivity (especially in pregnancy). HBeAg positive indicates high infectivity. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS HBV serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence assay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| | |
|---|---|
| **Test/Sample name** | **Hepatitis B genotype** |
| Sample type(s) required | Whole EDTA blood, Serum |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 28 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Colindale<br>UKAS: 8825 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Specific genotype reported |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Genotyping of infecting HBV at first detection. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

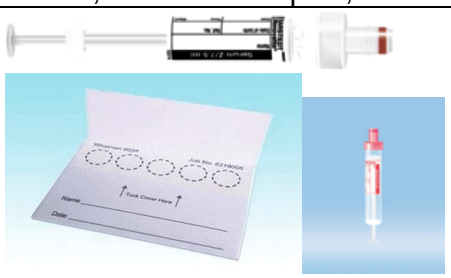
| Test/Sample name | **Hepatitis B surface Antibody (HBsAb)** |
|---|---|
| Sample type(s) required | Serum, plasma |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported in mIU/mL:<br><10mIU/mL<br>10-100mIU/mL<br>>100mIU/mL<br>Levels below 10mIU/mL indicate lack of vaccine response |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Tested to monitor response to HBV vaccination or assess for past infection |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS AntiHBs detection |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence assay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis B surface antigen (HBsAg)** |
|---|---|
| Sample type(s) required | Serum, including Infectious Diseases in Pregnancy screening (IDPS), Dried Blood Spots, plasma |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | IDPS, BBV screen, solid organ and bone marrow transplant donor and recipient screening |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA or Not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | BBV screening, acute hepatitis screening, antenatal screening, check for evidence of acute or chronic Hepatitis B infection. Check for evidence of response to treatment |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | Predominantly in house, but may be referred to UKHSA Colindale UKAS 8825 |
| EQA scheme participated | UK NEQAS HBV serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence |
| Timescale to add tests for sample types | 6 months, but this be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis C (HCV) genotype** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | On request |
| Turnaround time for 95% | 10 days |
| If referred and where to and their UKAS accreditation | Referred to MDU London UKAS:9003 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Genotype may affect treatment options. All new HCV positive patients with HCV RNA detected are referred for genotype testing. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis C (HCV) genotypic resistance** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Serum/plasma samples must be received in the lab within 6 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 15 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Colindale<br>UKAS 8825 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Detection of drug resistance in HCV positive patients. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis C antibody (HCV)** |
|---|---|
| Sample type(s) required | Serum, Dried Blood Spots, Plasma |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | BBV screen, solid organ and bone marrow transplant donor and recipient screening |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA or Not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | BBV screening, acute hepatitis screening, check for evidence of Hepatitis C infection.<br>Not suitable to monitor response to treatment (HCV RNA testing required) |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | In-house |
| EQA scheme participated | UK NEQAS HCV serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence assay for screening, confirmation on alternative chemiluminescence assay |
| Timescale to add tests for sample types | 6 months, but this be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis C RNA by quantitative PCR (HCV RNA)** |
|---|---|
| Sample type(s) required | Serum, Dried Blood Spots, Plasma |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Twice weekly |
| Turnaround time for 95% | 8 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by PCR or Not detected by PCR. Positive results are reported as IU/mL and log IU/mL.<br>DBS samples are reported as detected or not detected only. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Determination of HCV viral load. Used to confirm current infection and to monitor response to treatment |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS HCV RNA quantitation |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis D (HDV) RNA by PCR** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paediatric if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 28 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Colindale<br>UKAS: 8825 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by PCR or Not detected by PCR. Positive results are reported in copies/ml. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of active HDV infection. Only tested on known HBsAg positive patients. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis D serology (HDV)** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 15 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Colindale<br>UKAS: 8825 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Anti-HDV reactive or negative.<br>If reactive, anti-HDV IgM is performed.<br>Once patient is anti-HDV positive, further testing should be by HDV RNA. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of HDV infection. Only tested on known HBsAg positive patients |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | No (pending) |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | Hepatitis E (HEV) IgG |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected with interpretive comments, if appropriate |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of past Hepatitis E infection |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS Hepatitis E detection |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis E (HEV) IgM** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected with interpretive comments, if appropriate.<br>Positive results are phoned out by Virology medical staff. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of acute/ recent Hepatitis E (HEV) infection. Can be tested as part of investigation for raised ALT. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Positives are referred to Micropathology for HEV RNA testing by PCR |
| EQA scheme participated | UK NEQAS Hepatitis E detection |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hepatitis E RNA by PCR (referred)** |
|---|---|
| Sample type(s) required | Serum, plasma |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | 4.9mL EDTA blood or 7.9mL clotted blood |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily/as required |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Micropathology<br>UKAS: 9622 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as Not detected, or if detected, as copies/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of acute Hepatitis E infection.<br>Referred following in-house testing if HEV IgM is positive; may also be requested directly. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |
| Date details reviewed/due for review | August 2025 |

| Test/Sample name | **Herpes Simplex Virus (HSV) DNA quantitation** |
|---|---|
| Sample type(s) required | EDTA blood |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Micropathology<br>UKAS: 9622 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | N/A |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of disseminated HSV infection (e.g. neonates with sepsis or immunocompromised patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Quantitative PCR |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Herpes Simplex Virus (HSV) IgG** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected with interpretive comments, if appropriate |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of past HSV infection. Not suitable for diagnosis of current HSV infection. Assay cannot distinguish between HSV 1 and HSV 2 infections. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | HSV type-specific serology is referred if appropriate, with separate TRT |
| EQA scheme participated | Aurevia HSV serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Herpes Simplex Virus (HSV) type 1 DNA (genital)** |
|---|---|
| Sample type(s) required | Genital swabs in Virus transport medium |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | 1-2 times per week |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | HSV 1 and HSV 2 DNA tested as panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | N/A |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Evidence of primary or reactivated HSV infection |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD STI panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Herpes Simplex Virus (HSV) type 1 DNA** |
|---|---|
| Sample type(s) required | CSF, Skin, Throat, nose, mouth, & eye swabs |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Monday, Wednesday and Friday |
| Turnaround time for 95% ? separate TRT if requested as urgent/on-call | 3 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Non-respiratory viral panel comprising Herpes simplex virus (HSV) types 1 and 2, Varicella zoster virus (VZV), enterovirus, parechovirus, Cytomegalovirus (CMV), Epstein Barr virus (EBV) and Human Herpes Virus types 6 and 7 |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Positive eye swabs for HSV1/2 are only rung out if unclear patient is on antivirals. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspected herpes infection of skin and/or mucous membranes. CSF should be tested if viral encephalitis is suspected. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD CNS1 panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Herpes Simplex Virus (HSV) type 2 DNA (genital)** |
|---|---|
| Sample type(s) required | Genital swabs in Virus transport medium |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | 1-2 times per week |
| Turnaround time for 95% ? separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | HSV 1 and HSV 2 DNA tested as panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | N/A |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Evidence of primary or reactivated HSV infection |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD STI panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Herpes Simplex Virus (HSV) type 2 DNA** |
|---|---|
| Sample type(s) required | CSF, Skin, Throat, nose, mouth, & eye swabs |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Monday, Wednesday and Friday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 3 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Non-respiratory viral panel comprising Herpes simplex virus (HSV) types 1 and 2, Varicella zoster virus (VZV), enterovirus, parechovirus, Cytomegalovirus (CMV), Epstein Barr virus (EBV) and Human Herpes Virus types 6 and 7 |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Positive eye swabs for HSV1/2 are only rung out if unclear patient is on antivirals |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspected herpes infection of skin and/or mucous membranes. CSF should be tested if viral encephalitis is suspected. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD CNS1 panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Herpes Simplex Virus (HSV) type-specific serology** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 4 days |
| If referred and where to and their UKAS accreditation | Referred to Manchester Medical Microbiology partnership<br>UKAS: 8393 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported for both types. i.e., HSV type 1 IgG and HSV type 2 IgG detected or not detected |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Determination of specific type of past HSV infection (1 or 2); mainly used to assess risk of primary infection in pregnancy |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | EIA |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| **Test/Sample name** | **High Risk culture** |
|---|---|
| Sample type(s) required | Sputum, EndoTracheal (ET) aspirate, Bronchoalveolar Lavage (BAL) |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Process as soon as possible after collection, storage at 4°c |
| Testing frequency | Daily |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 4 days |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Isolates reported as isolated +, ++ or +++, no growth or no significant growth also reported |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | To culture significant pathogens from respiratory samples where there is suspicion of bacterial infection. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS General bacteriology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Manual culture |
| Timescale to add tests for sample types | 7 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | Histoplasma antibody |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) – minimum 0.5mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Mycology Reference Laboratory, Bristol - UKAS: 8043 |
| Normal ranges, where relevant, ? reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Not detected or Detected with a titre |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of exposure/ infection with fungus Histoplasma capsulatum |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Serology |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **HIV 1&2 combined ab/ag test** |
|---|---|
| Sample type(s) required | Serum, including Infectious Diseases in Pregnancy screening (IDPS), Dried Blood Spots, plasma |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | IDPS, BBV screen, solid organ and bone marrow transplant donor and recipient screening |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA or Not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of infection/ exposure to Human Immunodeficiency Virus (HIV). Not for monitoring response to treatment or testing for HIV vertical transmission. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | In house |
| EQA scheme participated | UK NEQAS HIV serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence assay for screening, and confirmation. chemiluminescence assay and typing as HIV-1 or HIV-2 using immunoblot method. |
| Timescale to add tests for sample types | 6 months, but this be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **HIV avidity** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 28 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Colindale<br>UKAS: 8825 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as low, moderate or high avidity |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Tested to assess whether new HIV diagnosis is due to recent infection. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **HIV Integrase resistance** |
|---|---|
| Sample type(s) required | Plasma |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 2 x 4.9 ml EDTA blood |
| Pre-analytics storage/transport | Transport to laboratory ASAP, ideally within 6 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 28 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Birmingham Heartlands<br>UKAS: 8213 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Detection of drug resistance RNA sequences |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **HIV PR (protease) and RT (Reverse Transcriptase) (genotypic) resistance** |
|---|---|
| Sample type(s) required | Plasma |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 2 x 4.9 ml EDTA blood |
| Pre-analytics storage/transport | Transport to laboratory ASAP, ideally within 6 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 28 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Birmingham Heartlands<br>UKAS: 8213 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Presence or absence of gene sequences suggesting drug resistance. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Detection of drug resistance RNA sequences.<br>Sample must have adequate levels of HIV-1 RNA to enable sequencing. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Pending |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |
| | |

| Test/Sample name | **HIV Proviral DNA** |
|---|---|
| Sample type(s) required | Whole EDTA blood |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 2 x 4.9 ml EDTA blood (maternal sample)<br>1.2mL EDTA blood (baby) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, ideally within 6 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 23 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Colindale<br>UKAS: 8825 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Investigation of possible HIV vertical transmission. Testing of mum and baby at birth and baby up to 12 months of age. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **HIV Tropism** |
|---|---|
| Sample type(s) required | Whole EDTA blood |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 2 x 4.9 ml EDTA blood (maternal sample)<br>1.2mL EDTA blood (baby) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, ideally within 6 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 28 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Birmingham Heartlands<br>UKAS: 8213 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Testing only available under Infection specialist advice if a certain group of ART (Anti-Retroviral Therapy) agents is being considered for the treatment of HIV. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **HIV-1 RNA quantitation by PCR** |
|---|---|
| Sample type(s) required | Plasma |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 2 x 4.9ml EDTA blood. - Use 1.2ml monovette for paediatric EDTA samples |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Three times weekly |
| Turnaround time for 95% | 7 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported in copies/mL and log copies/mL if positive (>=30 copies/mL) or as not detected by PCR if below limit of detection.<br>Samples may give results of detected but <30 copies/mL if below the limit of quantitation. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Quantitation of HIV-1 viral load |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS HIV-1 RNA quantitation |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **HIV-2 RNA quantitation by PCR** |
|---|---|
| Sample type(s) required | Plasma |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 2 x 4.9ml EDTA blood. - Use 1.2ml monovette for paediatric EDTA samples |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 7 days |
| If referred and where to and their UKAS accreditation | Referred to HSL (Analytics) LLP<br>UKAS: 8059 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported in copies/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Quantitation of HIV-2 viral load |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Human Herpes Virus type 6 (HHV6) DNA** |
|---|---|
| Sample type(s) required | CSF, Skin, Throat, nose, mouth, & eye swabs |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Monday, Wednesday and Friday |
| Turnaround time for 95% ? separate TRT if requested as urgent/on-call | 3 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Non-respiratory viral panel comprising Herpes simplex virus (HSV) types 1 and 2, Varicella zoster virus (VZV), enterovirus, parechovirus, Cytomegalovirus (CMV), Epstein Barr virus (EBV) and Human Herpes Virus types 6 and 7 |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of CNS infection (immunocompromised patients or paediatric group) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD TRANS panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Human Herpes Virus-7 (HHV-7) DNA by PCR (referred)** |
|---|---|
| Sample type(s) required | Whole EDTA blood |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 4.9mL EDTA blood |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Micropathology<br>UKAS: 9622 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | IU/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Disseminated HHV-7 infection suspected (immunocompromised patients or paediatric group) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Human Herpes Virus-8 (HHV-8) DNA by PCR (referred)** |
|---|---|
| Sample type(s) required | Whole EDTA blood, CSF |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | 4.9mL EDTA blood |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Colindale<br>UKAS: 8825 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | IU/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Disseminated HHV-8 infection suspected (immunocompromised patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Human T-cell Lymphotropic Virus (HTLV) types 1 and 2 IgG** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected with interpretive comments, if appropriate |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of past infection with Human T-cell Lymphotropic Virus (HTLV) types 1 or 2. Known positives should be monitored with DNA testing by PCR |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Positive samples referred for confirmation to UKHSA Colindale with separate TRT |
| EQA scheme participated | Aurevia HTLV serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Hydatid antibody (Echinococcus granulosus and multilocularis)** |
|---|---|
| Sample type(s) required | Serum. CSF may be tested alongside paired sera |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) – minimum 0.5mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 10 days |
| If referred and where to and their UKAS accreditation | Referred to Clinical Parasitology, HSL Analytics LLP at Hospital for Tropical Diseases (HTD) London - UKAS: 9702 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Positive or Negative |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of exposure/ hydatid disease caused by Echinococcus species |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | ELISA screen and Western Blot confirmation/speciation |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Influenza virus type A (Cepheid)** |
|---|---|
| Sample type(s) required | Throat Swab or Combined Nose and Throat Swabs in Virus Transport medium |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 2 hours. |
| Testing frequency | Daily |
| Turnaround time for 95% | 4 hours |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | Raid respiratory panel (Flu A, Flu B, RSV and SARS-CoV-2) |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of acute respiratory viral illness. Rapid testing available at LRI and GH on submission of samples with appropriate sticker on request forms. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Positive samples referred for additional typing, to UKHSA Colindale. UKAS: 8825 |
| EQA scheme participated | QCMD Respiratory I, QCMD Flu typing |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Influenza virus type A (Fusion)** |
|---|---|
| Sample type(s) required | Throat Swab or Combined Nose and Throat Swabs in Virus Transport medium |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 2 hours. |
| Testing frequency | Daily |
| Turnaround time for 95% | 1 day |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | Raid respiratory panel (Flu A, Flu B, RSV and SARS-CoV-2) |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of acute respiratory viral illness |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Positive samples referred for additional typing, to UKHSA Colindale. UKAS: 8825 |
| EQA scheme participated | QCMD Respiratory I, QCMD Flu typing |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Influenza virus type A** |
|---|---|
| Sample type(s) required | Respiratory Swab/Secretions, BAL, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Throat Swab or Combined Nose and Throat Swabs, Tissue |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days. |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | Extended respiratory viral panel comprising Influenza virus 1 and B, Respiratory Syncytial Virus (RSV) types A and B, Parainfluenza virus types 1,2 3 and 4, adenovirus, enterovirus, rhinovirus, parechovirus, metapneumovirus types A and B, Bocavirus, Coronavirus and SARS-CoV-2 virus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral respiratory tract infection (selected group of patients -neonates, children, augmented care, immunocompromised) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Positive samples referred for additional typing, to UKHSA Colindale. UKAS: 8825 |
| EQA scheme participated | QCMD Respiratory I, QCMD Flu typing |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Influenza virus type B (Cepheid)** |
|---|---|
| Sample type(s) required | Throat Swab or Combined Nose and Throat Swabs in Virus Transport medium |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 2 hours. |
| Testing frequency | Daily |
| Turnaround time for 95% | 4 hours |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | Raid respiratory panel (Flu A, Flu B, RSV and SARS-CoV-2) |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of acute respiratory viral illness Rapid testing available at LRI and GH on submission of samples with appropriate sticker on request forms. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Positive samples referred for additional typing, to UKHSA Colindale. UKAS: 8825 |
| EQA scheme participated | QCMD Respiratory I, QCMD Flu typing |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Influenza virus type B (Fusion)** |
|---|---|
| Sample type(s) required | Throat Swab or Combined Nose and Throat Swabs in Virus Transport medium |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 2 hours. |
| Testing frequency | Daily |
| Turnaround time for 95% | 1 day |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | Raid respiratory panel (Flu A, Flu B, RSV and SARS-CoV-2) |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of acute respiratory viral illness |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Positive samples referred for additional typing, to UKHSA Colindale. UKAS: 8825 |
| EQA scheme participated | QCMD Respiratory I, QCMD Flu typing |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Influenza virus type B** |
|---|---|
| Sample type(s) required | Respiratory Swab/Secretions, BAL, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Throat Swab or Combined Nose and Throat Swabs, Tissue |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Extended respiratory viral panel comprising Influenza virus 1 and B, Respiratory Syncytial Virus (RSV) types A and B, Parainfluenza virus types 1,2 3 and 4, adenovirus, enterovirus, rhinovirus, parechovirus, metapneumovirus types A and B, Bocavirus, Coronavirus and SARS-CoV-2 virus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral respiratory tract infection (selected group of patients -neonates, children, augmented care, immunocompromised) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Positive samples referred for additional typing, to UKHSA Colindale. UKAS: 8825 |
| EQA scheme participated | QCMD Respiratory I, QCMD Flu typing |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Isavuconazole levels** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 0.1mL serum |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 2 days |
| If referred and where to and their UKAS accreditation | Referred to Antimicrobial Reference Laboratory, Bristol<br>UKAS 8099 |
| Normal ranges, where relevant, reported as IU/mL etc | Expected level:<br>Pre dose: 2 - 4 mg/L (usually) |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | mg/L |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment with a pre dose sample taken up to an hour before oral administration. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Isoniazid level** |
|---|---|
| Sample type(s) required | Sodium oxalate blood |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Whole blood required (1-2mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% ? separate TRT if requested as urgent/on-call | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Antimicrobial Reference Laboratory, Bristol<br>UKAS 8099 |
| Normal ranges, where relevant, ? reported as IU/mL etc | Expected level:<br>Post dose: 3.0 – 5.0 mg/L |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | mg/L |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment with a post dose sample, taken 2 hours after the end of administration (and/or 6 hours if monitoring absorption) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Lamivudine assay** |
|---|---|
| Sample type(s) required | EDTA or Li-Hep plasma |
| Container (picture) | |
| Minimum sample volume (adult/paed if different) | 2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 4 hours. Store at 2 - 8 C if unable to transport within 4 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 14 days |
| If referred and where to and their UKAS accreditation | Referred to Cambridge Clinical Laboratories (Lab 21) - UKAS: 9325 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Drug concentration reported in ng/mL and with reference to dosing regime and required trough concentration |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 24 hours |
| Contact details for queries | Virology department |

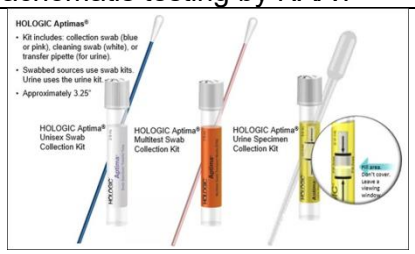
| Test/Sample name | **Legionella longbeachae DNA** |
|---|---|
| Sample type(s) required | BAL, Sputum, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Nasopharyngeal Swabs (inc. Pernasal Swabs), Nose/Throat Swabs |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | N/A |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | 2-3 times per week |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | |
| Normal ranges, where relevant, reported as IU/mL | N/A |
| Link to panel when tested as part of such | Pneumonia PCR panel comprising<br>Staph. aureus, Strep. pneumoniae, M. pneumoniae, Chlamydia pneumoniae, Chl. psittaci, Legionella pneumophila, Legionella longbeachae, Haemphilus spp, Pneumocystis jirovecii, Mycobacterium tuberculosis, Cryptococcus spp, Bordetella spp, Coxiella burnetii, and Aspergillus fumigatus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of pneumonia caused by atypical bacterial pathogens |
| Is it High Risk for sample transport if known/suspected? | N/A |
| Is confirmation testing in-house or referred | N/A |
| EQA scheme participated | QCMD Respiratory III |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Legionella urinary antigen** |
|---|---|
| Sample type(s) required | Urine (with or without Boric acid) |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Either plain sterile container or universal, or boric acid container is suitable. Fill to indicated line if using boric acid container. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 1 day |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Combined Legionella pneumophila and Streptococcus pneumonia urinary antigen panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as Detected or not detected |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of pneumonia caused by atypical bacterial pathogens |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Confirmed in house within stated TRT and referred to UKHSA Colindale for further confirmation |
| EQA scheme participated | UK NEQAS Urinary antigens |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Manual assay (Lateral Flow device) |
| Timescale to add tests for sample types | 7 days |
| Contact details for queries | Virology department |

| Test/Sample name | **Leishmania antibody** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) – minimum 0.5mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95%separate TRT if requested as urgent/on-call | 10 days |
| If referred and where to and their UKAS accreditation | Referred to Clinical Parasitology, HSL Analytics LLP at Hospital for Tropical Diseases (HTD) London - UKAS: 9702 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Agglutination titre is reported, >1600 is considered positive.<br>Rapid Ab test result reported as positive or negative |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of recent or past Leishmania infection following relevant travel history.<br>Not helpful in cases of suspected cutaneous Leishmaniasis. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Latex agglutination and rapid Ab test |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Leptospira IgM** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 6 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Rare and Imported Pathogen Laboratory (RIPL), Salisbury UKAS: 9304 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected<br>PCR may also be performed additionally by RIPL depending on clinical details and date of onset of symptoms/ exposure. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of acute/recent Leptospira infection following relevant exposure |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Levofloxacin assay** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 0.1mL serum |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Antimicrobial Reference Laboratory, Bristol<br>UKAS 8099 |
| Normal ranges, where relevant, reported as IU/mL etc | Expected levels: Pre: 0.5 - 2 mg/L<br>Post dose 8-13mg/L |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | mg/L |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment. Take a pre dose sample and a post dose sample, taken either 1 hour after the end of iv administration or 2 hours after oral administration. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **LGV (Lymphogranuloma venereum) DNA by PCR** |
|---|---|
| Sample type(s) required | Rectal swab received for Chlamydia trachomatis testing by NAAT |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | N/A |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 8 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Collindale<br>UKAS: 8825 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Both Chlamydia trachomatis and LGV specific DNA reported as Not detected or Detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Referred following in-house testing.<br>Only tested on rectal swabs from males, females with proctitis and LGV contacts with positive results for Chlamydia trachomatis DNA |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Linezolid level** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 0.1mL serum |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% ? separate TRT if requested as urgent/on-call | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Antimicrobial Reference Laboratory, Bristol<br>UKAS 8099 |
| Normal ranges, where relevant, ? reported as IU/mL etc | Expected levels: 600mg OD (Oral) Pre dose <5mg/L. Post dose 12-26mg/L. 600mg BD (Oral) Pre 2-8mg/L. Post 12-26mg/L |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | mg/L |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment, a pre dose sample and a post dose sample, taken either 1 hour after the end of iv administration or 2 hours after oral administration. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Lopinavir assay** |
|---|---|
| Sample type(s) required | EDTA or Li-Hep plasma |
| Container (picture) | |
| Minimum sample volume (adult/paed if different) | 2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 4 hours. Store at 2 - 8 C if unable to transport within 4 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 14 days |
| If referred and where to and their UKAS accreditation | Referred to Cambridge Clinical Laboratories (Lab 21) - UKAS: 9325 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Drug concentration reported in ng/mL and with reference to dosing regime and required trough concentration |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment |
| Is it High Risk for sample transport if known/suspected? | Yes – patient on HIV treatment |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 24 hours |
| Contact details for queries | Virology department |

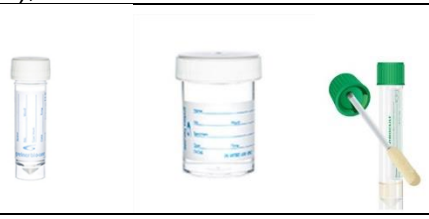
| Test/Sample name | **Measles IgG** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily. Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected with interpretive comments, if appropriate |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of past measles infection or immunisation. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Equivocal results may be referred with separate TRT, to UKHSA Colindale |
| EQA scheme participated | UK NEQAS Measles and Mumps IgG serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Measles IgM** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 6 days |
| If referred and where to and their UKAS accreditation | Referred to Measles reference lab, VRD, UKHSA Colindale - UKAS 8825 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of acute measles infection |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Measles RNA by PCR (referred)** |
|---|---|
| Sample type(s) required | Urine, EDTA blood, CSF, Throat Swab |
| Container (picture) |    |
| Minimum sample volume (adult/paed if different) | 4.9mL EDTA blood or 1mL faeces |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily/as required |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Birmingham Heartlands UKAS: 8213 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as Not detected, or Detected by PCR<br>Results in EDTA blood may be quantified as copies/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of acute measles infection. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Meningococcal (Neisseria meningitidis) PCR (referred)** |
|---|---|
| Sample type(s) required | Whole EDTA blood, CSF |
| Container (picture) |   |
| Minimum sample volume (adult/paediatric if different) | 2 x 4.9mL EDTA blood |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily/as required |
| Turnaround time for 95% | 4 days |
| If referred and where to and their UKAS accreditation | Referred to Manchester Medical Microbiology partnership (MMMP)<br>UKAS: 10175 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as Not detected, or if detected, as copies/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of disseminated Meningococcal Infection, septicaemia or meningitis |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **MERS (Middle East Respiratory Syndrome) Coronavirus PCR (referred)** |
|---|---|
| Sample type(s) required | Sputum, BAL or Endotracheal Aspirate, Nose and Throat Swabs |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Duplicate swabs required to enable follow-up testing at UHL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily/as required – treated as urgent |
| Turnaround time for 95% | 1-2 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Birmingham - UKAS: 8213 |
| Link to panel when tested as part of such | Respiratory panel tested including MERS as well as other coronavirus type RNA. |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as Not detected, or Detected by PCR<br>All positive viral RNA reported from panel as well as MERS and SARS-Cov-2 results |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of MERS in conjunction with a relevant travel history |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Legionella pneumophila DNA** |
|---|---|
| Sample type(s) required | BAL, Sputum, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Nasopharyngeal Swabs (inc. Pernasal Swabs), Nose/Throat Swabs |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | N/A |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | 2-3 times per week |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | Pneumonia PCR panel comprising<br>Staph. aureus, Strep. pneumoniae, M.pneumoniae, Chlamydia pneumoniae, Chl. psittaci, Legionella pneumophila, Legionella longbeachae, Haemphilus spp, Pneumocystis jirovecii, Mycobacterium tuberculosis, Cryptococcus spp, Bordetella spp, Coxiella burnetii, and Aspergillus fumigatus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of pneumonia caused by atypical bacterial pathogens |
| Is it High Risk for sample transport if known/suspected? | N/A |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Respiratory III |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests | N/A |
| Contact details for queries | Virology department |

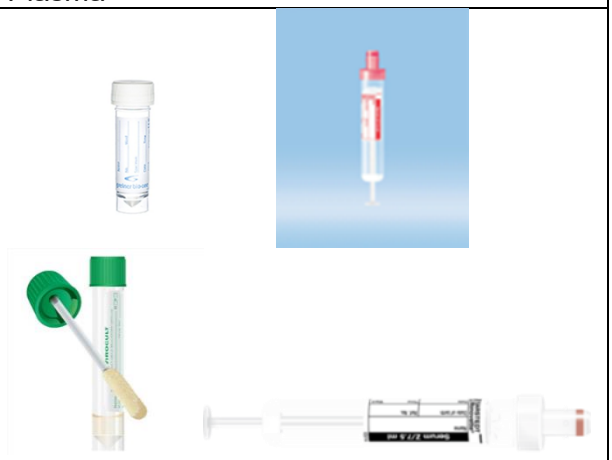
| Test/Sample name | **Metapneumovirus types A and B RNA** |
|---|---|
| Sample type(s) required | Respiratory Swab/Secretions, BAL, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Throat Swab or Combined Nose and Throat Swabs, Tissue |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Extended respiratory viral panel comprising Influenza virus 1 and B, Respiratory Syncytial Virus (RSV) types A and B, Parainfluenza virus types 1,2 3 and 4, adenovirus, enterovirus, rhinovirus, parechovirus, metapneumovirus types A and B, Bocavirus, Coronavirus and SARS-CoV-2 virus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral respiratory tract infection (selected group of patients -neonates, children, augmented care, immunocompromised) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Respiratory II panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

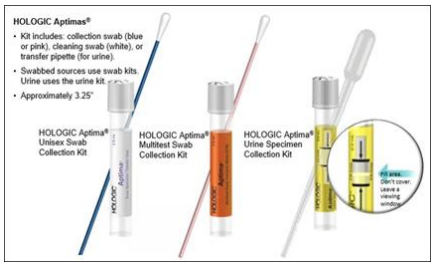
| Test/Sample name | **Moxifloxacin level** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 0.1mL serum |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Antimicrobial Reference Laboratory, Bristol<br>UKAS 8099 |
| Normal ranges, where relevant, ?reported as IU/mL etc | Expected levels: Pre: 0.3 - 0.7 mg/L<br>Post dose 3-5 mg/L |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | mg/L |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment with a pre dose sample and a post dose sample, taken 2 hours after oral administration. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **MRSA (Methicillin-resistant Staphylococcus aureus) screen** |
|---|---|
| Sample type(s) required | Gel Amies plain swab (Blue cap) - from suitable site (nose, perineum) |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | N/A |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | In house |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Isolated or Not isolated |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for colonisation with MRSA (if indicated as per UHL's MRSA Prevention, Management and Screening Policy) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In house |
| EQA scheme participated | NEQAS MRSA Screen |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Manual culture |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Bacteriology department |
| Link to antibiotic website ?other relevant guidance | LLR Antimicrobial guidelines |

| Test/Sample name | **Mumps IgG** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected with interpretive comments, if appropriate |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Evidence of past infection with mumps or immunisation |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Equivocal results may be referred with separate TRT, to UKHSA Colindale |
| EQA scheme participated | UK NEQAS Measles and Mumps IgG serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

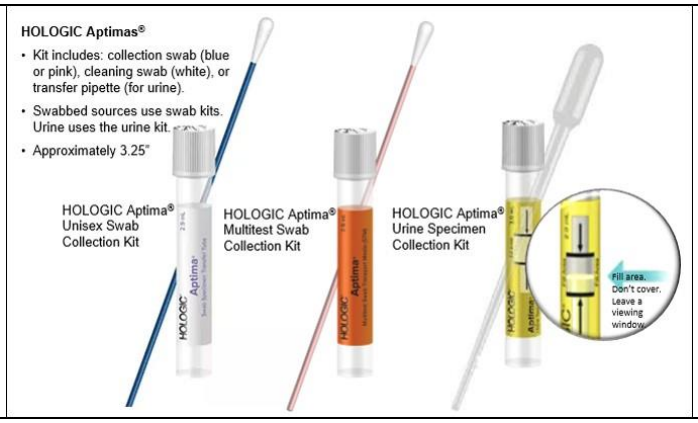
| Test/Sample name | **Mumps IgM** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | Mumps IgM and IgG usually tested together |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected with interpretive comments, if appropriate |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of acute mumps infection |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Equivocal results may be referred with separate TRT to UKHSA Colindale |
| EQA scheme participated | Aurevia mumps serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Mumps virus E RNA by PCR (referred)** |
|---|---|
| Sample type(s) required | CSF, Urine, Mouth/Throat Swab, Serum, Plasma |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily/as required |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Micropathology<br>UKAS: 9622 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as Not detected, or if detected, as copies/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of Mumps |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Mycoplasma genitalium DNA by PCR (referred)** |
|---|---|
| Sample type(s) required | Genital Swabs, Urine |
| Container (picture) |  <br>  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily/as required |
| Turnaround time for 95% | 4 days |
| If referred and where to and their UKAS accreditation | Referred to Micropathology<br>UKAS: 9622 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as Not detected, or if detected, as copies/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of Mycoplasma genitalium infection (STI) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Mycoplasma pneumoniae DNA** |
|---|---|
| Sample type(s) required | BAL, Sputum, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Nasopharyngeal Swabs (inc. Pernasal Swabs), Nose/Throat Swabs |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | N/A |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | 2-3 times per week |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | Pneumonia PCR panel comprising<br>Staph. aureus, Strep. pneumoniae, M. pneumoniae, Chlamydia pneumoniae, Chl. psittaci, Legionella pneumophila, Legionella longbeachae, Haemphilus spp, Pneumocystis jirovecii, Mycobacterium tuberculosis, Cryptococcus spp, Bordetella spp, Coxiella burnetii, and Aspergillus fumigatus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of pneumonia caused by atypical bacterial pathogens |
| Is it High Risk for sample transport if known/suspected? | N/A |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Respiratory III |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Mycoplasma pneumoniae IgM** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL)<br>Paediatric clotted blood 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | Referred to Queen's Medical Centre, Nottingham<br>UKAS: 8755 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | IgM Positive or Negative<br>Positive result suggests recent infection |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of acute/recent Mycoplasma pneumoniae infection |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| **Test/Sample name** | **Neisseria gonorrhoeae DNA** |
|---|---|
| Sample type(s) required | Urine, Genital Swab, Rectal swab, Eye swab, Throat Swab |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8°C if unable to transport within 24 hours of collection. |
| Testing frequency | 3 times a week |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Chlamydia trachomatis and Neisseria gonorrhoeae NAAT testing performed as panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as detected or not detected by NAATs.<br>Positive eye swabs and samples from pregnant patients phoned out |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of Neisseria gonorrhoeae infection. This test can also be requested on eye samples from a neonate if ophthalmia neonatorum is suspected |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Positives confirmed in-house within stated TRT |
| EQA scheme participated | QCMD STD II panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Norovirus antigen** |
|---|---|
| Sample type(s) required | Faeces |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 1 day |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as Detected or not detected |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral gastroenteritis (D&V), especially with outbreaks (winter vomiting disease) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS viral gastroenteritis |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Manual assay (Lateral Flow device) |
| Timescale to add tests for sample types | 7 days |
| Contact details for queries | Virology department |

| Test/Sample name | **Ova, cysts & parasites** |
|---|---|
| Sample type(s) required | Faeces, Urine, Sellotape slide, dry peri-anal swab |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | 5mL blue top universal as part of faeces screen, Sterile universal not in boric acid for urine. |
| Pre-analytics storage/transport | If not processed quickly, store at 2-8 C until ready for processing |
| Testing frequency | Daily (Monday to Friday) |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | In-house |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Seen or not seen |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Ensure full relevant travel history and appropriate clinical details are included on the form; failure to supply this will result in OCP not being tested. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS parasitology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Microscopy following Parasep modified formol ether concentration or centrifugation |
| Timescale to add tests for sample types | 7 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Parainfluenza virus types 1, 2, 3 and 4 RNA** |
|---|---|
| Sample type(s) required | Respiratory Swab/Secretions, BAL, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Throat Swab or Combined Nose and Throat Swabs, Tissue |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Extended respiratory viral panel comprising Influenza virus 1 and B, Respiratory Syncytial Virus (RSV) types A and B, Parainfluenza virus types 1,2 3 and 4, adenovirus, enterovirus, rhinovirus, parechovirus, metapneumovirus types A and B, Bocavirus, Coronavirus and SARS-CoV-2 virus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral respiratory tract infection (selected group of patients -neonates, children, augmented care, immunocompromised) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Respiratory II panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Parechovirus RNA (respiratory)** |
|---|---|
| Sample type(s) required | Respiratory Swab/Secretions, BAL, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Throat Swab or Combined Nose and Throat Swabs, Tissue |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Extended respiratory viral panel comprising Influenza virus 1 and B, Respiratory Syncytial Virus (RSV) types A and B, Parainfluenza virus types 1,2 3 and 4, adenovirus, enterovirus, rhinovirus, parechovirus, metapneumovirus types A and B, Bocavirus, Coronavirus and SARS-CoV-2 virus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral respiratory tract infection (selected group of patients -neonates, children, augmented care, immunocompromised) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Respiratory II panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

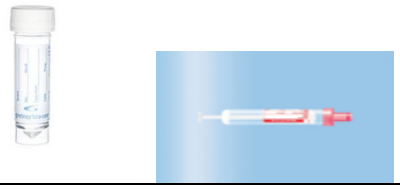
| Test/Sample name | **Parvovirus B19 DNA by PCR (quantitative)** |
|---|---|
| Sample type(s) required | EDTA blood/plasma, serum, tissue |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8°C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | Referred to Micropathology, Coventry UKAS 9622 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Not detected by NAAT or quantitation in IU/mL and log IU/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of disseminated Parvovirus B19 virus infection (immunocompromised patients).<br>Serum may be referred to confirm acute infection when Parvovirus IgM is positive. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Pending |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 1 week |
| Contact details for queries | Virology department |

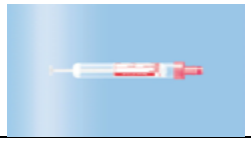
| Test/Sample name | **Parvovirus B19 IgG** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL)<br>Paediatric clotted blood 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | ToRCH screening |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA, Not detected by EIA or Weakly detected by EIA when IgG present may not be sufficient to confer immunity following exposure. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of past Parvovirus B19 infection/immunity in symptomatic patients (especially during pregnancy) or following exposure. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS Parvovirus and Rubella serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent Immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

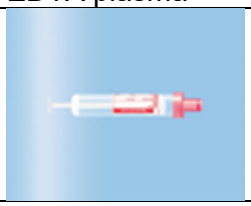
| **Test/Sample name** | **Parvovirus B19 IgM** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) Paediatric clotted blood 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | ToRCH screening |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA, Not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of acute/recent Parvovirus B19 infection in symptomatic patients (especially during pregnancy) or following exposure. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Parvovirus IgM positive samples are referred for Parvovirus B19 PCR testing with a separate TRT. |
| EQA scheme participated | UK NEQAS Parvovirus and Rubella serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescent Immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Pneumocystis jirovecii (PCP) DNA by PCR (referred)** |
|---|---|
| Sample type(s) required | Sputum or BAL |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8°C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | Referred to Micropathology, Coventry UKAS 9622 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by NAAT |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Clinical and/or radiological suspicion of Pneumocystis jirovecii pneumonia |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Pending |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 1 week |
| Contact details for queries | Virology department |

| Test/Sample name | **Pneumocystis jirovecii DNA** |
|---|---|
| Sample type(s) required | BAL, Sputum, Endotracheal Secretions, NPA, Nasopharyngeal Swabs (inc. Pernasal Swabs), Nose/Throat Swabs |
| Container (picture) |  |
| Minimum sample volume | N/A |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | 2-3 times per week |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant, ? reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | Pneumonia PCR panel comprising Staph. aureus, Strep. pneumoniae, M. pneumoniae, Chlamydia pneumoniae, Chlamydia psittaci, Legionella pneumophila, Legionella longbeachae, Haemphilus spp, Pneumocystis jirovecii, Mycobacterium tuberculosis, Cryptococcus spp, Bordetella spp, Coxiella burnetii, and Aspergillus fumigatus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors | Clinical or radiological suspicion of Pneumocystis jirovecii pneumonia |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD PCP |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Polyoma BK virus DNA by PCR (quantitative)** |
|---|---|
| Sample type(s) required | EDTA blood/plasma or urine (NOT in boric acid) |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 5mL whole blood |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8°C if unable to transport within 24 hours of collection. |
| Testing frequency | Twice weekly |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | N/A<br>Most commonly requested with EBV and/or CMV DNA |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Not detected by NAAT or if detected, quantitation in IU/mL and log IU/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of disseminated BK virus infection (immunocompromised patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD BKV DNA |
| Is test UKAS accredited (refer to sample types if necessary) | Pending |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | 1 week |
| Contact details for queries | Virology department |

| Test/Sample name | **Polyoma JC virus DNA by PCR** |
|---|---|
| Sample type(s) required | CSF, EDTA blood |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8°C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Micropathology, Coventry UKAS 9622 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of disseminated JC virus infection (immunocompromised patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 1 week |
| Contact details for queries | Virology department |

| Test/Sample name | **Pyrazinamide assay** |
|---|---|
| Sample type(s) required | EDTA plasma |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 4.9mL EDTA blood |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection.<br>Collect sample 2 hours post dose. |
| Testing frequency | As required |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 7 days |
| If referred and where to and their UKAS accreditation | Referred to Toxicology laboratory, Cardiff UKAS 8989 |
| Normal ranges, where relevant, reported as IU/mL etc | 20-40mg/L for peak does based on daily dose regimen |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | mg/L |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **QuantiFERON** |
|---|---|
| Sample type(s) required | Whole blood in either 4 QuanitFERON bottles or Lithium heparin bottle (see below) |
| Container (picture) |    |
| Minimum sample volume (adult/paed if different) | 4 tubes filled to stated marker (approximately 1mL per tube), Lithium Heparin (LiHe) tube = 4mL |
| Pre-analytics storage/transport | Samples should be kept between 22 + 5° C and arrive a maximum 16hrs post venepuncture or 12 hours for LiHe. Samples must arrive in Microbiology before 17:00 Monday to Friday for processing. **Do not refrigerate** |
| Testing frequency | Daily, Monday to Friday |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | In house |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Negative by EIA, Postive by EIA, Indeterminate by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | To test for evidence of latent TB |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| Factors known to affect result | Samples must be received in lab within 16 hours (4 QFN tubes) or 12hrs (Lithium heparin) of collection |
| EQA scheme participated | UK NEQAS IIA IGRA |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Enzyme Immunoassay |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Raltegravir assay** |
|---|---|
| Sample type(s) required | EDTA or Li-Hep plasma |
| Container (picture) | |
| Minimum sample volume (adult/paed if different) | 2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 4 hours. Store at 2 - 8 C if unable to transport within 4 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 14 days |
| If referred and where to and their UKAS accreditation | Referred to Cambridge Clinical Laboratories (Lab 21) - UKAS: 9325 |
| Normal ranges, where relevant,reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Drug concentration reported in ng/mL and with reference to dosing regime and required trough concentration |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment |
| Is it High Risk for sample transport if known/suspected? | Yes – patient on HIV treatment |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 24 hours |
| Contact details for queries | Virology department |

| Test/Sample name | **Respiratory Syncytial Virus (RSV) (Cepheid)** |
|---|---|
| Sample type(s) required | Throat Swab or Combined Nose and Throat Swabs in Virus Transport medium |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 2 hours. |
| Testing frequency | Daily |
| Turnaround time for 95% | 4 hours |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | Raid respiratory panel (Flu A, Flu B, RSV and SARS-CoV-2) |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of acute respiratory viral illness Rapid testing available at LRI and GH on submission of samples with appropriate sticker on request forms. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | |
| EQA scheme participated | QCMD Respiratory I |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Respiratory Syncytial Virus (RSV) (Fusion)** |
|---|---|
| Sample type(s) required | Throat Swab or Combined Nose and Throat Swabs in Virus Transport medium |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 2 hours. |
| Testing frequency | Daily |
| Turnaround time for 95% | 1 day |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | Raid respiratory panel (Flu A, Flu B, RSV and SARS-CoV-2) |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of acute respiratory viral illness |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Respiratory I |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Respiratory syncytial virus (RSV) A and B RNA** |
|---|---|
| Sample type(s) required | Respiratory Swab/Secretions, BAL, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Throat Swab or Combined Nose and Throat Swabs, Tissue |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% ? separate TRT if requested as urgent/on-call | 2 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Extended respiratory viral panel comprising Influenza virus 1 and B, Respiratory Syncytial Virus (RSV) types A and B, Para-influenza virus types 1,2 3 and 4, adenovirus, enterovirus, rhinovirus, parechovirus, metapneumovirus types A and B, Bocavirus, Coronavirus and SARS-CoV-2 virus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral respiratory tract infection (selected group of patients -neonates, children, augmented care, immunocompromised) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Respiratory I panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

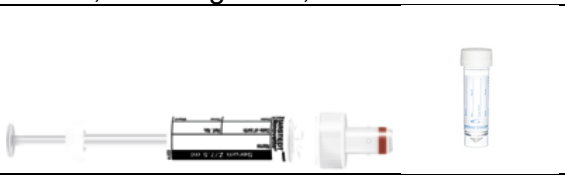
| Test/Sample name | **Rhinovirus RNA** |
|---|---|
| Sample type(s) required | Respiratory Swab/Secretions, BAL, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Throat Swab or Combined Nose and Throat Swabs, Tissue |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Extended respiratory viral panel comprising Influenza virus 1 and B, Respiratory Syncytial Virus (RSV) types A and B, Parainfluenza virus types 1,2 3 and 4, adenovirus, enterovirus, rhinovirus, parechovirus, metapneumovirus types A and B, Bocavirus, Coronavirus and SARS-CoV-2 virus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral respiratory tract infection (selected group of patients -neonates, children, augmented care, immunocompromised) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Respiratory II panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| **Test/Sample name** | **Rifampicin assay** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 0.1mL serum |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Antimicrobial Reference Laboratory, Bristol<br>UKAS 8099 |
| Normal ranges, where relevant, reported as IU/mL etc | Expected levels:<br>Pre <0.5 mg/L<br>Post <4 mg/L sub-therapeutic<br>Post 4-8 mg/L usually adequate<br>Post 8-24 mg/L ideal |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | mg/L |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment with a pre dose sample and a post dose sample taken 1 hour after iv administration or three post dose samples, taken 1 hour, 2 hours and 4 hours after oral administration. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Ritonavir assay** |
|---|---|
| Sample type(s) required | EDTA or Li-Hep plasma |
| Container (picture) | |
| Minimum sample volume (adult/paed if different) | 2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 4 hours. Store at 2 - 8 C if unable to transport within 4 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 14 days |
| If referred and where to and their UKAS accreditation | Referred to Cambridge Clinical Laboratories (Lab 21) - UKAS: 9325 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Drug concentration reported in ng/mL and with reference to dosing regime and required trough concentration |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment |
| Is it High Risk for sample transport if known/suspected? | Yes – patient on HIV treatment |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 24 hours |
| Contact details for queries | Virology department |

| Test/Sample name | **Rotavirus antigen** |
|---|---|
| Sample type(s) required | Faeces |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 1 day |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Tested in panel with Adenovirus antigen |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as Detected or not detected |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral diarrhoea (children, immunocompromised patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | Aurevia ROAD antigens |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Manual assay (Lateral Flow device) |
| Timescale to add tests for sample types | 7 days |
| Contact details for queries | Virology department |

| **Test/Sample name** | **Routine culture** |
|---|---|
| Sample type(s) required | Gel Amies swab with charcoal from suitable sites. |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | N/A |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8° C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Friday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 4 working days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Isolates reported as isolated +, ++ or +++, no growth or no significant growth also reported |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Culture significant pathogens in cases where bacterial infection is suspected (wound, skin and soft tissue etc) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS General bacteriology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Manual culture |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Bacteriology department |

| **Test/Sample name** | **RPR Titre** |
|---|---|
| Sample type(s) required | Serum, including IDPS, CSF |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL); serum gel tubes are accepted. Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Twice weekly, Monday and Thursday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | Syphilis confirmation |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Negative or titre (doubling values from Neat, 1:2, 1:4 etc) |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Confirmation of syphilis positive screens and monitoring during/post treatment |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS syphilis serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes (serum only) |
| Method/analyser used | Particle agglutination |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Rubella IgG** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 2 days |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant, reported as IU/mL etc | Reported as Rubella antibody positive when >=10 IU/mL |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Rubella antibody PRESENT or Rubella antibody Not detected |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of past Rubella infection or immunisation |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS Parvovirus and Rubella serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence assay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Rubella IgM** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL). Use 1.2ml monovette for paediatric samples. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 2 days |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | ToRCH screen |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA or Not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of acute/recent Rubella infection |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS Parvovirus and Rubella serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence assay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Salmonella spp** |
|---|---|
| Sample type(s) required | Faeces - Faecal sample container with spoon (Blue cap). |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 5 mL |
| Pre-analytics storage/transport | Within 24 hours if stored at ambient temperature. Within 5 days if stored at 2-8°C |
| Testing frequency | Daily |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | In-house testing: positives referred UKHSA Colindale-UKAS:8197 |
| Link to panel when tested as part of such | Enteric PCR panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by PCR or Not detected by PCR Samples may be reported as invalid if repeat testing fails to generate a result. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | This assay is intended for use with liquid/loose stool samples, types 5-7 on the Bristol Stool Chart. Formed stool samples, types 1-4 are reported stating that the sensitivity of the assay may be reduced, and results should be interpreted with caution. No testing within 7 days of a previous sample |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In-house culture methods may be used to confirm or speciate positive results. These have a separate TRT |
| EQA scheme participated | UK NEQAS General Bacteriology (Campylobacter, Salmonella, Shigella, Vibrio & Yersinia), QCMD Bacterial gastroenteritis (Salmonella, Shigella, Yersinia, E. coli O157, Campylobacter) |
| Is test UKAS accredited (refer to sample types if necessary) | Accredited |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | 5 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **SARS-CoV-2 Virus (Cepheid)** |
|---|---|
| Sample type(s) required | Throat Swab or Combined Nose and Throat Swabs in Virus Transport medium |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 2 hours. |
| Testing frequency | Daily |
| Turnaround time for 95% | 4 hours |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | Raid respiratory panel (Flu A, Flu B, RSV and SARS-CoV-2) |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of acute respiratory viral illness Rapid testing available at LRI and GH on submission of samples with appropriate sticker on request forms. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | |
| EQA scheme participated | QCMD Respiratory I |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **SARS-CoV-2 Virus (Fusion)** |
|---|---|
| Sample type(s) required | Throat Swab or Combined Nose and Throat Swabs in Virus Transport medium |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 2 hours. |
| Testing frequency | Daily |
| Turnaround time for 95% | 1 day |
| If referred and where to and their UKAS accreditation | In-house |
| Link to panel when tested as part of such | Raid respiratory panel (Flu A, Flu B, RSV and SARS-CoV-2) |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of acute respiratory viral illness. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Respiratory I |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | N/A |

| Test/Sample name | **SARS-CoV-2 RNA** |
|---|---|
| Sample type(s) required | Respiratory Swab/Secretions, BAL, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Throat Swab or Combined Nose and Throat Swabs, Tissue |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | N/A |
| Link to panel when tested as part of such | Extended respiratory viral panel comprising Influenza virus 1 and B, Respiratory Syncytial Virus (RSV) types A and B, Parainfluenza virus types 1,2 3 and 4, adenovirus, enterovirus, rhinovirus, parechovirus, metapneumovirus types A and B, Bocavirus, Coronavirus and SARS-CoV-2 virus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral respiratory tract infection (selected group of patients -neonates, children, augmented care, immunocompromised) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Respiratory II panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Schistosoma antibody** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) – minimum 0.5mL serum |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 10 days |
| If referred and where to and their UKAS accreditation | Referred to Clinical Parasitology, HSL Analytics LLP at Hospital for Tropical Diseases (HTD) London - UKAS: 9702 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Positive results are reported at Levels 1 to 9. Levels 1 and 2 are regarded as weak positives; Levels 5 and over are strong positives |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence Schistosomal infection following exposure to fresh water in endemic areas. Positive results not expected until 6-12/52 post-exposure. Repeat testing not recommended until 18 months post-treatment |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | EIA (Enzyme ImmunoAssay) |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Seasonal Coronavirus RNA** |
|---|---|
| Sample type(s) required | Respiratory Swab/Secretions, BAL, Endotracheal Secretions, Nasopharyngeal Aspirate (NPA), Throat Swab or Combined Nose and Throat Swabs, Tissue |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 2 days |
| If referred and where to and their UKAS accreditation | N/A |
| Link to panel when tested as part of such | Extended respiratory viral panel comprising Influenza virus 1 and B, Respiratory Syncytial Virus (RSV) types A and B, Parainfluenza virus types 1,2 3 and 4, adenovirus, enterovirus, rhinovirus, parechovirus, metapneumovirus types A and B, Bocavirus, Coronavirus and SARS-CoV-2 virus |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or Not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of viral respiratory tract infection (selected group of patients -neonates, children, augmented care, immunocompromised) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD Respiratory II panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Shigella spp** |
|---|---|
| Sample type(s) required | Faeces - Faecal sample container with spoon (Blue cap). |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 5 mL |
| Pre-analytics storage/transport | Within 24 hours if stored at ambient temperature. Within 5 days if stored at 2-8°C |
| Testing frequency | Daily |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | N/A |
| Link to panel when tested as part of such | Enteric PCR panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by PCR or Not detected by PCR Samples may be reported as invalid if repeat testing fails to generate a result. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | This assay is intended for use with liquid/loose stool samples, types 5-7 on the Bristol Stool Chart. Formed stool samples, types 1-4 are reported stating that the sensitivity of the assay may be reduced, and results should be interpreted with caution |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In-house culture methods may be used to confirm or speciate positive results. These have a separate TRT |
| EQA scheme participated | UK NEQAS General Bacteriology (Campylobacter, Salmonella, Shigella, Vibrio & Yersinia), QCMD Bacterial gastroenteritis (Salmonella, Shigella, Yersinia, E. coli O157, Campylobacter) |
| Is test UKAS accredited (refer to sample types if necessary) | Accredited |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | 5 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Single organism screen (faeces)** |
|---|---|
| Sample type(s) required | Faeces - Faecal sample container with spoon (Blue cap). |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 5mL |
| Pre-analytics storage/transport | If not processed quickly, store at 2-8oC until ready for processing |
| Testing frequency | Daily (Monday to Friday) |
| Turnaround time for 95% | 4 days |
| If referred and where to and their UKAS accreditation | In-house |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Isolated or not isolated with organism name |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Determination of clearance of previously identified faecal pathogen (e.g. for food-handlers) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS General bacteriology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Direct culture of faeces |
| Timescale to add tests for sample types | 7 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **STEC (Shiga-toxin producing E.coli)** |
|---|---|
| Sample type(s) required | Faeces - Faecal sample container with spoon (Blue cap). |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 5 mL |
| Pre-analytics storage/transport | Within 24 hours if stored at ambient temperature. Within 5 days if stored at 2-8°C |
| Testing frequency | Daily |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | In house testing; positives that fail to grow referred to UKHSA Colindale-UKAS:8197. E coli 0157 isolates referred to UKHSA Birmingham UKAS 8213 |
| Link to panel when tested as part of such | Enteric PCR panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by PCR or Not detected by PCR Samples may be reported as invalid if repeat testing fails to generate a result. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | This assay is intended for use with liquid/loose stool samples, types 5-7 on the Bristol Stool Chart. Formed stool samples, types 1-4 are reported stating that the sensitivity of the assay may be reduced, and results should be interpreted with caution. No testing within 7 days of previous sample. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In-house culture methods may be used to confirm or speciate positive results. These have a separate TRT |
| EQA scheme participated | UK NEQAS General Bacteriology (Campylobacter, Salmonella, Shigella, Vibrio & Yersinia), QCMD Bacterial gastroenteritis (Salmonella, Shigella, Yersinia, E. coli O157, Campylobacter) |
| Is test UKAS accredited (refer to sample types if necessary) | Accredited |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | 5 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Streptococcal pneumoniae (Pneumococcal) urinary antigen** |
|---|---|
| Sample type(s) required | Urine |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | Either plain sterile container or universal, or boric acid container is suitable. Fill to indicated line if using boric acid container. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 1 day |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Combined Legionella pneumophila and Streptococcus pneumonia urinary antigen panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as Detected or not detected |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of pneumonia caused by atypical bacterial pathogens |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Confirmed in-house within stated TRT |
| EQA scheme participated | UK NEQAS urinary antigens |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Manual assay (Lateral Flow device) |
| Timescale to add tests for sample types | 7 days |
| Contact details for queries | Virology department |

| **Test/Sample name** | **Streptomycin level** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Antimicrobial Reference Laboratory, Bristol<br>UKAS 8099 |
| Normal ranges, where relevant, reported as IU/mL etc | Expected level (15 mg/kg OD)<br>Pre: <5 mg/L in <50y patients<br>Pre: <1 mg/L in >50y patients<br>Post: 15 - 40 mg/L<br>Expected level (025 mg/kg BIW):<br>Pre: <1 mg/L<br>Post: 65 - 80 mg/L |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | mg/L |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Strongyloides antibody** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 10 days |
| If referred and where to and their UKAS accreditation | Referred to Clinical Parasitology, HSL Analytics LLP at Hospital for Tropical Diseases (HTD) London - UKAS: 9702 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Positive or negative |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of recent or past Strongyloides infection. Repeat testing not recommended until 12 months after treatment |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | EIA (Enzyme ImmunoAssay) |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Syphilis (Treponemal) antibody** |
|---|---|
| Sample type(s) required | Serum including IDPS |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 2 days (if negative) |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | Infectious Diseases in Pregnancy Screening (IDPS) |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA or Not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of infection with or exposure to Treponema pallidum (syphilis) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | If reactive samples cannot be confirmed in-house, they may be referred for confirmation. In-house and referred confirmation have separate TRT |
| EQA scheme participated | UK NEQAS Syphilis serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence assay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Syphilis (Treponemal) DNA by PCR** |
|---|---|
| Sample type(s) required | CSF, genital swab in VTM |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8°C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | Micropathology, Coventry<br>UKAS 9622 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of acute syphilis or neurosyphilis |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 1 week |
| Contact details for queries | Virology department |

| Test/Sample name | **TB (Mycobacterium tuberculosis) culture** |
|---|---|
| Sample type(s) required | Sputum, BAL, CSF, tissues |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Sputum specimens should be fresh (< 1day) to minimise contaminants. Purulent specimens are best. 2-3 samples of approximately 5ml of specimens should be collected approximately 8-24 hours apart, with at least one from early morning. Urine specimens should be collected in the early morning on 3 consecutive days in a universal container (not in boric acid).<br>For BAL and CSF, minimum sample size is preferably 5mL. |
| Pre-analytics storage/transport | Process as soon as possible after collection, storage at 4ºc |
| Testing frequency | Daily, Monday to Friday |
| Turnaround time for 95% | 7-10 weeks |
| If referred and where to and their UKAS accreditation | NMRS<br>UKAS - 8213 |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Mycobacterial species isolated or culture for Mycobacteria negative after 6 weeks incubation. Medical staff contact TB services/ clinicians via phone / email as appropriate |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of Tuberculosis |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | Referred with separate TRT for determination of mycobacterial species and/or genotypic resistance, if required |
| EQA scheme participated | UK NEQAS mycobacterial culture |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Culture |
| Timescale to add tests for sample types | 1 week |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **TB (Mycobacterium tuberculosis) microscopy** |
|---|---|
| Sample type(s) required | Sputum, BAL, CSF, tissues |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Sputum specimens should be fresh (< 1day) to minimise contaminants. Purulent specimens are best. 2-3 samples of approximately 5ml of specimens should be collected approximately 8-24 hours apart, with at least one from early morning. Urine specimens should be collected in the early morning on 3 consecutive days in a universal container (not in boric acid).<br>For BAL and CSF, minimum sample size is preferably 5mL. |
| Pre-analytics storage/transport | Process as soon as possible after collection, storage at 4º C |
| Testing frequency | Daily, Monday to Friday |
| Turnaround time for 95% | Next day |
| If referred and where to and their UKAS accreditation | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | First time smear-positive or PCR-positive TB sample results phoned out |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of Tuberculosis |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | In-house |
| EQA scheme participated | UK NEQAS mycobacterial microscopy |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Auramine staining/microscopy |
| Timescale to add tests for sample types | 1 week |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **TB (Mycobacterium tuberculosis) PCR** |
|---|---|
| Sample type(s) required | Sputum, BAL, PCR, tissues. Only sputum is validated for this test. |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 0.75mL |
| Pre-analytics storage/transport | Process as soon as possible after collection, storage at 4ºc |
| Testing frequency | Daily, Monday to Friday |
| Turnaround time for 95% | Next day |
| If referred and where to and their UKAS accreditation | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | First time smear-positive or PCR-positive TB sample results phoned out |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of Tuberculosis |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | In-house |
| EQA scheme participated | QCMD MTB PCR and QCMD MTB resistance panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | PCR |
| Timescale to add tests for sample types | 3 months |
| Contact details for queries | Bacteriology department |

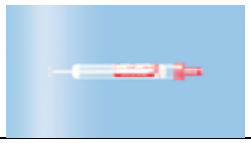
| Test/Sample name | **Teicoplanin level** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 0.1mL serum |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 2 days |
| If referred and where to and their UKAS accreditation | Referred to Antimicrobial Reference Laboratory, Bristol<br>UKAS 8099 |
| Normal ranges, where relevant, reported as IU/mL etc | Expected level (S.aureus)<br>a) Skin and soft tissue infection – Pre dose 15-30 mg/L but <60mg/L<br>b) Bone and Joint infection – Pre dose 20-40 mg/L but <60 mg/L<br>c) Infective endocarditis – Pre dose 30-40 mg/L but <60 mg/L<br>d) OPAT on 25 mg/kg 3x per week – Pre dose 20-30 mg/L |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | mg/L |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment but Pre dose sample only required. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Tenofovir assay** |
|---|---|
| Sample type(s) required | EDTA or Li-Hep plasma |
| Container (picture) | |
| Minimum sample volume (adult/paed if different) | 2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 4 hours. Store at 2 - 8 C if unable to transport within 4 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 14 days |
| If referred and where to and their UKAS accreditation | Referred to Cambridge Clinical Laboratories (Lab 21) - UKAS: 9325 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Drug concentration reported in ng/mL and with reference to dosing regime and required trough concentration |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment |
| Is it High Risk for sample transport if known/suspected? | Yes – patient on HIV treatment |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 24 hours |
| Contact details for queries | Virology department |

| Test/Sample name | **Tissues, fluid and pus- microscopy and culture** |
|---|---|
| Sample type(s) required | Tissue, fluid [CSF, synovial, ascitic, peritoneal dialysis (PD), sample from nephrostomy] or pus in a sterile container. |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | N/A |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily Monday to Sunday. (out of hours service for urgent requests) |
| Turnaround time for 95%. | 6 days for culture. |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant | **CSF**<br>Red Blood Cells (RBC): Nil<br>White Blood Cells (WBC): Neonates (less 28 days) 0-30 x $10^6$/L; Infants (1 to 12 months) 0-15 x $10^6$/L; Children/ Adults (Over 1 year) 0-5 x $10^6$/L<br><br>**Ascitic fluid**- WBC count of >250 x $10^6$/L are suggestive of spontaneous bacterial peritonitis (SPB)<br><br>**Peritoneal Dialysis (PD) fluid**- WBC >100 x $10^6$/L correlates closely with infection |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Growth of significant pathogens, no growth or no significant growth reported. Critical results are phoned out by medical staff.<br><br>All urgently requested tests are phoned out once microscopy is complete. Microscopy of |

| | |
|---|---|
| | corneal scrapes, CSF and peritoneal dialysis fluids are also phoned out by BMS once complete. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Culture significant pathogens from patients in whom a bacterial infection is suspected. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In-house |
| EQA scheme participated | UK NEQAS General Bacteriology<br>BMS Micro Cerebrospinal Fluid<br>Lab Quality Synovial fluid crystals |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Manual culture |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Toxocara antibody** |
|---|---|
| Sample type(s) required | Serum. Aqueous humour, vitreous humour or CSF may be tested on request |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) - minimum 0.5mL serum |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 10 days |
| If referred and where to and their UKAS accreditation | Referred to Clinical Parasitology, HSL Analytics LLP at Hospital for Tropical Diseases (HTD) London - UKAS: 9702 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Toxocara IgG reported as detected or not detected |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of recent or past Toxocara infection following exposure to infected dog or cat |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | EIA (Enzyme ImmunoAssay) |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

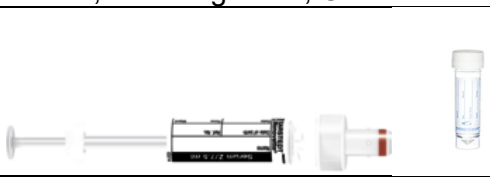
| Test/Sample name | **Toxoplasma DNA by PCR** |
|---|---|
| Sample type(s) required | CSF, EDTA blood |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8°C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | Micropathology, Coventry<br>UKAS 9622 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of acute or disseminated Toxoplasmosis |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 1 week |
| Contact details for queries | Virology department |

| Test/Sample name | **Toxoplasma Dye test** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | N/A – testing added within Virology following in-house testing |
| Testing frequency | As required |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 9 days |
| If referred and where to and their UKAS accreditation | Referred to Toxoplasma Reference Unit, Swansea<br>UKAS: 9510 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Further investigation of immunocompromised patients or neonates with history of Toxoplasma gondii infection |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Toxoplasma IgG avidity** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | In-house |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A – added in-house to assist in interpretation of unusual Toxoplasma IgM and IgG results |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported as High, moderate or low avidity. Low avidity indicates recent infection. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Assess how recent was prior infection with Toxoplasma gondii, especially in relation to infection during pregnancy |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS Toxoplasma serology |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | Chemiluminescent immunoassay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Toxoplasma IgG** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL)<br>Paediatric clotted blood sample 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | In-house. Some positive samples may be referred for Toxoplasma Dye test to Toxoplasma Reference Unit, Swansea<br>UKAS: 9510 |
| Link to panel when tested as part of such | ToRCH, solid organ and bone marrow donor and recipient screening |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA or Not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of past infection with Toxoplasma gondii.<br>However, a negative result does not rule out acute/recent infection |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | If referred, separate TRT involved |
| EQA scheme participated | UK NEQAS Toxoplasma serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence assay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Toxoplasma IgM** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL)<br>Paediatric clotted blood sample 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily, Monday to Saturday |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | In-house. |
| Link to panel when tested as part of such | Glandular fever screening |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by EIA or Not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of acute/recent Toxoplasma gondii infection |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS Toxoplasma serology |
| Is test UKAS accredited (refer to sample types if necessary) | Accreditation Pending |
| Method/analyser used | Chemiluminescence assay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **TPHA (Treponemal pallidum haem-agglutination)** |
|---|---|
| Sample type(s) required | Serum, Including IDPS, CSF |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Twice weekly, Monday and Thursday |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 5 days |
| If referred and where to and their UKAS accreditation | N/A |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | Syphilis confirmation of new positives |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Positive or Negative |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Confirm positive results obtained in treponemal antibody screening assay |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS syphilis serology |
| Is test UKAS accredited (refer to sample types if necessary) | Yes (serum only) |
| Method/analyser used | Particle agglutination |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Treponemal IgM** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 10 days |
| If referred and where to and their UKAS accreditation | Referred to UKHSA Bristol<br>UKAS: 8043 |
| Normal ranges, where relevant, ? reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by EIA |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Determination of acute/recent infection with Treponema pallidum when in-house screening is suggestive of new infection |
| Is it High Risk for sample transport if known/suspected? | |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Trichinella antibody** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 10 days |
| If referred and where to and their UKAS accreditation | Referred to Clinical Parasitology, HSL Analytics LLP at Hospital for Tropical Diseases (HTD) London - UKAS: 9702 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Check for evidence of recent or past Trichinella infection |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | IFAT (immunofluorescence Antibody test) |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Ureaplasma DNA** |
|---|---|
| Sample type(s) required | Urine, NPA (neonates) or genital swab |
| Container (picture) | |
| Minimum sample volume (adult/paed if different) | Plain 60ml container or sterile universal |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 2 days |
| If referred and where to and their UKAS accreditation | Referred to Micropathology<br>UKAS: 9622 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected or not detected by PCR |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Test NPA if suspicion of disseminated ureaplasma infection in neonates. Test urine or genital swabs if suspicion of non-gonococcal urethritis (NGU) in adults. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Urine culture** |
|---|---|
| Sample type(s) required | Urine - Mid-stream Urine, Catheter Urine including Urine Vacutest Kima tubes |
| Container (picture) |    |
| Minimum sample volume (adult/paed if different) | Fill boric acid container to fill line to allow appropriate dilution of boric acid |
| Pre-analytics storage/transport | Samples without Boric Acid should be processed within 4 hours or refrigerated for up to 48 hours.<br>In Boric Acid, urine may be processed up to 96 hours from collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 4 days |
| If referred and where to and their UKAS accreditation | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | No growth, $10^4$-$10^5$ organisms/mL or >$10^5$ organisms/mL with significant individual organisms reported with sensitivities if appropriate. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of urinary tract infection (UTI) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In-house |
| EQA scheme participated | UK NEQAS General Bacteriology and Antimicrobial Susceptibility<br>Lab Quality Urine culture, quantitative screening |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Manual culture |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Urine microscopy** |
|---|---|
| Sample type(s) required | Urine - Mid-stream Urine, Catheter Urine including Urine Vacutest Kima tubes |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Fill boric acid containers to fill line to allow appropriate dilution of boric acid |
| Pre-analytics storage/transport | Samples without Boric Acid should be processed within 4 hours or refrigerated for up to 48 hours.<br>In Boric Acid, urine may be processed up to 96 hours from collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 1 day |
| If referred and where to and their UKAS accreditation | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | For samples where automated Microscopy sis performed, white cells and epithelial cells are reported as normal or high for each cell type. For samples where manual microscopy is performed, red and white blood cells are reported as 0,5,30,80,>100, profuse or obscured. Presence of epithelial cells, casts, and yeast cells is also reported. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of Urinary tract infection (UTI). The following always have manual microscopy: non-boric acid urines with volumes <3mL, urgent samples, urines with specific requests for casts, high-risk urines, supra-pubic aspirates and prostatic massage samples. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | Urine culture is performed on samples with indicative microscopy results and/or clinical details. |
| EQA scheme participated | Lab Quality Urine strip test B, particle count and estimation of density |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Manual and automated microscopy |
| Timescale to add tests for sample types | 3 days |
| Contact details for queries | Bacteriology department |

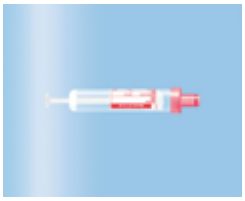
| Test/Sample name | **Varicella zoster (VZ) IgG** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | Plain clotted blood sample (serum Z/7.5mL)<br>Paediatric clotted blood sample 1.2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Daily |
| Turnaround time for 95% | 5 days<br>May be tested/reported within 24 hours for pregnant or immunocompromised contacts |
| If referred and where to and their UKAS accreditation | In house |
| Normal ranges, where relevant, ? reported as IU/mL etc | Reported in mIU/mL<br>Levels >100mIU/mL considered adequate to demonstrate immunity unless immunocompromised. |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Reported in mIU/mL<br>Results for non-immune pregnant and immuno-compromised contacts will be phoned out. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | To establish immunity to chickenpox (varicella zoster or VZV) or requirement for post-exposure treatment |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | UK NEQAS VZ IgG detection |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Chemiluminescence assay |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Varicella zoster virus (VZV) DNA by PCR (quantitation)** |
|---|---|
| Sample type(s) required | EDTA blood |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 4.9mL EDTA blood (adult)<br>2.7mL EDTA blood (paed) |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | Referred to Micropathology, Coventry<br>UKAS 9622 |
| Link to panel when tested as part of such | |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Not detected, or quantitation in IU/mL |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of disseminated Varicella zoster infection (immunocompromised patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Varicella zoster virus (VZV) DNA** |
|---|---|
| Sample type(s) required | CSF, Skin, mouth, & eye swabs |
| Container (picture) |  Plain 60ml container or sterile universal, or swab in Virus Transport medium |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | Monday, Wednesday and Friday |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | In house |
| Link to panel when tested as part of such | Non-respiratory viral panel comprising Herpes simplex virus (HSV) types 1 and 2, Varicella zoster virus (VZV), enterovirus, parechovirus, Cytomegalovirus (CMV), Epstein Barr virus (EBV) and Human Herpes Virus types 6 and 7 |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Positive eye swabs for VZV are only rung out if unclear patient is on antivirals |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspected varicella infection of skin and/or mucous membranes. CSF should be tested if varicella encephalitis is suspected (usually immunocompromised patients) |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | QCMD CNS1 panel |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | |
| Contact details for queries | Virology department |

| Test/Sample name | **Vibrio spp** |
|---|---|
| Sample type(s) required | Faeces - Faecal sample container with spoon (Blue cap). |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 5 mL |
| Pre-analytics storage/transport | Within 24 hours if stored at ambient temperature. Within 5 days if stored at 2-8°C |
| Testing frequency | Daily |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | In house testing: positives referred UKHSA Colindale:8197 |
| Link to panel when tested as part of such | Enteric PCR panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by PCR or Not detected by PCR Samples may be reported as invalid if repeat testing fails to generate a result. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | This assay is intended for use with liquid/loose stool samples, types 5-7 on the Bristol Stool Chart. Formed stool samples, types 1-4 are reported stating that the sensitivity of the assay may be reduced, and results should be interpreted with caution. No testing within 7 days of a previous sample. |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In-house culture methods may be used to confirm or speciate positive results. These have a separate TRT |
| EQA scheme participated | UK NEQAS General Bacteriology (Campylobacter, Salmonella, Shigella, Vibrio & Yersinia), QCMD Bacterial gastroenteritis (Salmonella, Shigella, Yersinia, E. coli O157, Campylobacter) |
| Is test UKAS accredited (refer to sample types if necessary) | Accredited |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | 5 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Virus panel serology** |
|---|---|
| Sample type(s) required | Serum |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | At least 800ul of serum. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 7 days |
| If referred and where to and their UKAS accreditation | Referred to Rare and Imported Pathogens Laboratory, Salisbury - UKAS: 9304 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | Imported fever panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Evidence of acute or past infection, or no evidence of infection at any time with wide range of imported/exotic viruses |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Symptomatic patients following foreign travel. Travel dates, places of travel and clinical details are essential. |
| Is it High Risk for sample transport if known/suspected? | Yes |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

| Test/Sample name | **Whipples (Tropheryma whipplei) PCR** |
|---|---|
| Sample type(s) required | EDTA whole blood or CSF |
| Container (picture) |   |
| Minimum sample volume (adult/paed if different) | |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | As required |
| Turnaround time for 95% | 5 days |
| If referred and where to and their UKAS accreditation | Referred to Leeds Teaching Hospital UKAS: 9862 |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Suspicion of Whipple's Disease |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | PCR |
| Timescale to add tests for sample types | N/A |
| Contact details for queries | Virology department |

| Test/Sample name | **Yersinia enterocolitica** |
|---|---|
| Sample type(s) required | Faeces - Faecal sample container with spoon (Blue cap). |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | 5 mL |
| Pre-analytics storage/transport | Within 24 hours if stored at ambient temperature. Within 5 days if stored at 2-8°C |
| Testing frequency | Daily |
| Turnaround time for 95% | 3 days |
| If referred and where to and their UKAS accreditation | In house testing: positives referred to UKHSA Colindale-UKAS:8197 |
| Link to panel when tested as part of such | Enteric PCR panel |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Detected by PCR or Not detected by PCR Samples may be reported as invalid if repeat testing fails to generate a result. |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | This assay is intended for use with liquid/loose stool samples, types 5-7 on the Bristol Stool Chart. Formed stool samples, types 1-4 are reported stating that the sensitivity of the assay may be reduced, and results should be interpreted with caution |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | In-house culture methods may be used to confirm or speciate positive results. These have a separate TRT |
| EQA scheme participated | UK NEQAS General Bacteriology (Campylobacter, Salmonella, Shigella, Vibrio & Yersinia), QCMD Bacterial gastroenteritis (Salmonella, Shigella, Yersinia, E. coli O157, Campylobacter) |
| Is test UKAS accredited (refer to sample types if necessary) | Accredited |
| Method/analyser used | Molecular |
| Timescale to add tests for sample types | 5 days |
| Contact details for queries | Bacteriology department |

| Test/Sample name | **Zidovudine assay** |
|---|---|
| Sample type(s) required | EDTA or Li-Hep plasma |
| Container (picture) | |
| Minimum sample volume (adult/paed if different) | 2mL |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 4 hours. Store at 2 - 8 C if unable to transport within 4 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 14 days |
| If referred and where to and their UKAS accreditation | Referred to Cambridge Clinical Laboratories (Lab 21) - UKAS: 9325 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | Drug concentration reported in ng/mL and with reference to dosing regime and required trough concentration |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Monitoring drug levels while on treatment |
| Is it High Risk for sample transport if known/suspected? | Yes – patient on HIV treatment |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | No |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | 24 hours |
| Contact details for queries | Virology department |

| Test/Sample name | **Zika virus testing** |
|---|---|
| Sample type(s) required | Serum, urine.<br>EDTA blood is NOT appropriate |
| Container (picture) |  |
| Minimum sample volume (adult/paed if different) | At least 800ul of serum. |
| Pre-analytics storage/transport | Transport to laboratory ASAP, within 24 hours. Store at 2 - 8 C if unable to transport within 24 hours of collection. |
| Testing frequency | N/A |
| Turnaround time for 95% separate TRT if requested as urgent/on-call | 7 days |
| If referred and where to and their UKAS accreditation | Referred to Rare and Imported Pathogens Laboratory, Salisbury - UKAS: 9304 |
| Normal ranges, where relevant, reported as IU/mL etc | N/A |
| Link to panel when tested as part of such | N/A |
| How result is reported, what is significant/clinical decision point, is it phoned out/when? | |
| Reasons for testing – related clinical syndromes, risk factors (? When NOT appropriate) | Imported viral infection following foreign travel. Travel dates, places of travel and clinical details are essential |
| Is it High Risk for sample transport if known/suspected? | No |
| Is confirmation testing in-house (included in TRT?) or referred | N/A |
| EQA scheme participated | N/A |
| Is test UKAS accredited (refer to sample types if necessary) | Yes |
| Method/analyser used | N/A |
| Timescale to add tests for sample types | The time limit for additional testing on archived serum samples is 6 months, but this can be extended at the discretion of the Consultant Virologist. |
| Contact details for queries | Virology department |

# 20 Appendix: Sample Request Forms

Can be ordered from Pathology stores

## Bacteriology request form

PZ 307 Bacteriology request form FRONT

## Virology request form

Virology form (front).pdf

## Antenatal request form for IDPS

V4 front.PDF.pdf

V4 back.PDF.pdf