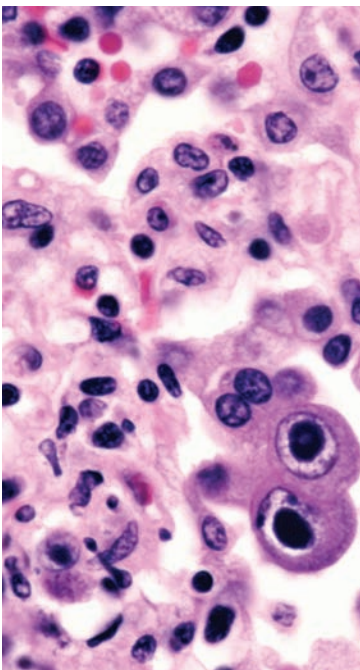


Lab Updates

An archive of *Lab Updates* is posted on Our Net or external web site: <http://www.ummlabs.org>

Change in Cytomegalovirus Quantitative Testing



AS OF JUNE 18, 2007, THE CYTOMEGALOVIRUS QUANTITATIVE ASSAY will be performed using Real-Time PCR. CMV genomic DNA is isolated, a conserved DNA region is amplified by polymerase chain reaction (PCR) and the resulting product is measured on by Real-Time PCR. The analytical measurement range of the assay is 600 – 4,200,000 copies/ml CMV. Validation of this assay method change was performed in our Molecular Diagnostics Laboratory using samples previously analyzed by MALDI-TOF Mass Spectrometry in our laboratory. The study demonstrated a good correlation of results between the two methods. The Real-Time PCR method will permit a shortened assay TAT. There is no change in test ordering or sample tube type. The report will indicate the change in methodology.

If you require further information or have comments or concerns, please contact:

Dr. Edward Ginns, Director, Molecular Diagnostics at 508-856-8134 or via email at Edward.Ginns@umassmed.edu, or

Dr. Michael Mitchell, Director, Microbiology at 508-334-7160 or via email at MitcheM@ummhc.org, or

Dr. Marzena Galdzicka, Scientific Director, Molecular Diagnostics at 508-856-4384 or via email at Marzena.Galdzicka@umassmed.edu

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L. Michael Snyder, MD
Chairman
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Clinical Laboratories



New Patient Service Center Opening in July

We are one of the largest laboratory providers in New England

UMass Memorial Laboratories will be opening a Patient Service Center (phlebotomy draw station) at 675 Paramount Drive, Raynham, MA.

The vision of UMass Memorial Laboratories is:

- To be one of the top ten academic medical center-based laboratories in the United States by 2008, as well as
- To be a leading provider of laboratory services throughout New England, meeting the needs of patients and providers in the region



675 Paramount Drive, Raynham, MA

The Raynham Patient Service Center is located at 675 Paramount Dr., Suite 102, Raynham, MA. The hours are Monday through Friday 8:00am-5:00pm, closed 12:15pm-12:45pm. The phone number at the Raynham PSC is 508-824-0838.



Genetic Counselors are available for questions through client services

Last Name _____	MRN _____
First Name _____	
Birth date/Age _____	Sex _____
Address _____	
City _____	State _____ Zip Code _____
Phone _____	
CARD STAMP	

Collection date: ___/___/___ Time _____

Ordering Physician: _____ UPN# _____

Signature: _____

Phone: _____ Fax: _____

ICD-9 _____

First Trimester Maternal Screen

Draw specimen between 11 weeks, 0 days and 13 weeks, 6 days gestation. (CRL=4.2 -7.9cm)

Sequential Maternal Screen

Specimen #1: Draw specimen between 10 weeks, 3 days and 13 weeks, 6 days gestation. (CRL=3.6 -7.9cm)

Specimen #2: Draw specimen between 15 weeks, 0 days and 22 weeks, 6 days gestation.

Ultrasound information must be collected between 10 weeks, 3 days and 13 weeks, 6 days gestation. If the patient's NT measurement cannot be obtained, the first trimester or sequential screens cannot be ordered.

MATERNAL SERUM/FLUID SCREENING ASSAYS

0081293 Maternal Screening, Sequential, Specimen #1 (MS SEQ1)

0081294 Maternal Screening, Sequential, Specimen #2 (MS SEQ2)

0081150 Maternal Screening, First Trimester ONLY (MSFIRST)

0080269 Quad only (QUAD)

0080434 AFP -ONLY (MSAFP)

0080427 AFP Amniotic fluid/reflux to Acetylcholinesterase (AFAFP)

Date of Ultrasound _____

Name of Sonographer _____

Certification # of Sonographer _____

Reading M.D. _____

NT (mm) _____

CRL (cm) _____

If Twins: Twin B NT (mm) _____

Twin B CRL (cm) _____

REQUIRED PATIENT INFORMATION

A. Current weight _____ lbs

B. Due date (EDC) _____ Determined by Last menstrual period date: ___/___/___ Ultrasound, date: ___/___/___

C. Number of Fetuses: Singleton Twins Triplets Unknown Check box if pregnancy is monochorionic

D. Patient's race? Caucasian Black Hispanic Asian Other

E. Is the patient an insulin dependent diabetic? No Yes

F. Is there a family history of a neural tube defect? No Yes If yes, relationship to fetus? _____

G. Has the patient had a previous pregnancy with a chromosome abnormality? (e.g., Down syndrome, Trisomy 18 or 13) No Yes If yes, specify abnormality _____

H. Is this an *in vitro* fertilization pregnancy using a DONOR egg? No Yes If yes, age of egg donor _____ years

I. Has patient taken valproic acid or carbamazepine during this pregnancy? No Yes If yes, specify drug _____

J. Is this a repeat sample? No Yes Unknown

Specimen Submission Form

STATE LABORATORY INSTITUTE
305 South Street
Jamaica Plain, MA 02130-3597
Tel. 617-983-6200

Do not use this space

PLEASE PRINT

DO NOT ABBREVIATE

1. SEND RESULTS TO:

UMass Memorial Medical Center, Inc.
Department of Hospital Laboratories
Biotech I-Suite 200
365 Plantation Street
Worcester, MA 01605
Phone number: (508-334-2863 Main lab customer service)

2. PATIENT INFORMATION

Name _____
Address _____
Phone () _____
Patient ID _____

3. ORDERING PHYSICIAN/CONTACT - NAME

Phone Number () _____

4. Sex M F Other | Date of Birth ____/____/____

Ethnicity Hispanic or Latino Not Hispanic or Latino

Race (check one) American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

Other

5. TEST REQUESTED: _____

Reason: Symptomatic Test of Cure Surveillance
 Confirmation Contact

Presumptive ID _____

For: Identification Isolation Typing
(----- Complete Section 7-----)

Serology (Complete Section 6)

Other (specify) _____

6. SEROLOGY

Serum Spinal Fluid

Acute Convalescent Late Convalescent

Date Collected ____/____/____

7. CULTURE: Specimen collected is: (Please check one and complete date collected or date of subculture)

Original Material. Collected ____/____/____ Subculture. Date Subculture Made: ____/____/____

Has specimen been treated? Yes No Specify method _____

Source of specimen:

- | | | | |
|--------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Anal Canal | <input type="checkbox"/> Pharynx | <input type="checkbox"/> Throat | <input type="checkbox"/> Wound (site) |
| <input type="checkbox"/> Blood | <input type="checkbox"/> Plasma | <input type="checkbox"/> Urethra | <input type="checkbox"/> Exudate (site) |
| <input type="checkbox"/> Bone Marrow | <input type="checkbox"/> Serum | <input type="checkbox"/> Urine | <input type="checkbox"/> Tissue (specify) |
| <input type="checkbox"/> Cervix | <input type="checkbox"/> Spinal Fluid | <input type="checkbox"/> Body Fluid (site) | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Gastric | <input type="checkbox"/> Sputum | <input type="checkbox"/> Bronchus (site) | |
| <input type="checkbox"/> Nasopharynx | <input type="checkbox"/> Stool | | |

8. FOR VIRUS SEROLOGY, VIRUS ISOLATION and TESTS LISTED AS CDC SEROLOGY or CDC CULTURE IN THE SLI MANUAL OF TESTS and SERVICES.

Symptoms, Date of Onset and Duration _____

Travel History (and dates of travel) _____

Animal/Arthropod Contact (specify) _____

Previous Laboratory Results _____

Relevant Immunizations (give dates) _____

Additional Information: _____