www.wisconsinlab.com
Phone: (262) 574-0701
Fax: (262) 574-0703

Wisconsin Viral Research Group

Test Request Form

W229 N1870 Westwood Drive
Waukesha, Wisconsin 53186

Enclose completed form with sample. *Rev 09-2013*

I. Patient Information

Name (last, first): Date of Birth: M/F

Address: Phone:

II. Ordering Physician Information: *Please include a FAX number for result reporting*

Name: UPIN#:

Address:

FAX Results To: Phone: Contact Person:

III. Payment Information:

Please note: Our laboratory does not bill patients, patient's insurance or Medicare**

Payment by: (choose one) Check Money Order Credit Card (fill out information below)

Name on Credit Card:

Credit Card Information: (circle one) VISA Master Card Discover American Express

Credit Card Number: | | | | | | | | | | | | | | | | | Exp Date:

All self-paying patients will receive a standard HCFA insurance submission form for insurance purposes.

****Medicare Advance Beneficiary Notice**

These tests are not covered by Medicare unless you are an organ transplant recipient or a patient with HIV Disease. I understand that Medicare will not pay for my testing.

_____ Patient Signature

IV. Specimen Information: (circle one) Blood CSF Bone Marrow Other _____

Date Collected ((Required) Phleb**:**

V. ICD-9 Code(s): Required (systemic complaint and/or diagnosis) 1) 2) 3) 4)

VI. Tests:

_____ Nested HCMV DNA PCR (#1400) _____ Nested HHV-6 DNA PCR (#1100)

_____ Nested EBV DNA PCR (#1200) _____ HHV-7 DNA PCR (#1300)

Shipping Instructions: FedEx is our preferred shipper. Ship Monday through Thursday using the "PRIORITY OVERNIGHT - NEXT BUSINESS MORNING" shipping option.
Ship to:

Wisconsin Viral Research Group, Inc.
W229 N1870 Westwood Drive
Waukesha, Wisconsin 53186

For Lab Use Only Received: Accn # Mailer