

Test Request Requisition

To BE COMPLETED BY THE SENDING INSTITUTION: Print and Fill Out Completely			To BE COMPLETED BY VERSITI:	
Patient Last Name:			Sample volume acceptable? <input type="checkbox"/> Yes <input type="checkbox"/> No: <input type="checkbox"/> QNS <input type="checkbox"/> Broken	
Patient First Name:		Date of Birth:	If no: Person notified:	
Sample Collection Date:	# Tubes Sent:	Sample Collection Time:	Date Notified: Notified By:	
Sample Type: <input type="checkbox"/> Plasma <input type="checkbox"/> Serum <input type="checkbox"/> Other: (May check more than one box)			Comments:	
Attending physician (if applicable):				
Institution:			Patient & Sample Cerner Entry by: Date:	
Address:			Sample Information Verified & Labeled by: Date:	
Name/Phone number to phone results to:		Name/Fax number to send results to:	Sample ID Labels Verified by: Date:	
<input checked="" type="checkbox"/>	Testing Required			
	IDT Transplant Evaluation (Includes: HIV-1/2 Plus O, HCV, HBsAg, HBc, HTLV-I/II, CMV, Syphilis, NAT HIV-1/HCV/HBV)			
	ABO and Rh Grouping (IDT ABO/Rh)			
	Cytomegalovirus (CMV) Antibody			
	Hepatitis B Core Antibody (HBc)			
	Hepatitis B Surface Antigen (HBsAg)			
	Hepatitis C Virus Antibody (HCV)			
	*HIV-1/2 Plus O Antibody Combination			
	HTLV-I/II Antibody			
	*Nucleic Acid Amplification (NAT) - HIV-1/HCV/HBV			
	Red Cell Antibody screen (IAT – Indirect Antiglobulin)			
	Syphilis (STS)			
	T. cruzi Antibody			
	West Nile Virus (WNV)			
	Other:			
*A signed consent form must be obtained from the patient and maintained as a permanent record of the primary health care provider.			DO NOT PHOTOCOPY THIS FORM Copies of this form may be printed from our website: www.versiti.org	