638 N. 18th Street
Milwaukee, WI 53233-2121
Phone: (414) 937-6110 Fax: (414) 937-6278 www.versiti.org

TEST REQUEST REQUISITION

TO BE COMPLETED BY THE SENDING INSTITUTION: Print and Fill Out Completely		
Patient Last Name:		
Patient First Name:		Date of Birth:
Sample Collection Date:	# Tubes Sent:	Sample Collection Time:
Sample Type: ☐ Plasma ☐ Serum ☐ Other: (May check more than one box)		
Attending physician (if applicable):		
Institution:		
Address:		
Name/Phone number to phone results to:	Name/Fax number to send results to:	

✓	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.

TO BE COMPLETED BY VERSITI:	
Sample volume acceptable? ☐ Yes ☐ No: ☐ QNS ☐ Broken	
If no: Person notified: Date Notified: Notified By:	
Comments:	
Patient & Sample Cerner Entry by:	Date:
Sample Information Verified & Labeled by:	Date:
Sample ID Labels Verified by:	Date:
Sample Transferred by:	Date:
Aliquot Transfer Verified by:	Date:

Affix One Sample ID Label Here:
(Affix remaining labels on the back of this form):

Affix Cerner Label(s) Here:

DO NOT PHOTOCOPY THIS FORM
Copies of this form may be printed from our website: www.versiti.org