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BLOODCENTER of WISCONSIN™
PART OF VERSITI

TEST REQUEST REQUISITION

TO BE COMPLETED BY THE SENDING INSTITUTION: Please 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 BCW:	
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.bcw.edu