Cytomegalovirus (CMV) Test Requisition

Please complete every field and tick box clearly.

PATIENT INFORMATION

Patient's First Name
Middle Initial
MM/ DD /YYYY
Patient's Date of Birth
Patient's Last Name
Mother's First and Last Name

Biological Sex: ○Male ○Female ○Unknown
Gender Identity (if different from above): ____________________

Patient's Street Address
City / Town
State
Zip Code
Country
Patient's Preferred Phone

Ethnicity (check all that apply):	○African-American	○Asian (China, Japan, Korea)
○Caucasian/N. European/S. European	○Finnish	○French Canadian
○Hispanic ○Jewish - Ashkenazi	○Jewish - Sephardic	○Mediterranean
○Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)	○Native American	○E. Indian
○Southeast Asian (Vietnam, Cambodia, Thailand)	○South Asian (India, Pakistan)	
○Other (specify) ____________________		

PATIENT SAMPLE INFORMATION

SAMPLE TYPE:

● Dried Blood Spots
Filter Paper Number ____________________

TEST MENU

[ ] **Cytomegalovirus (CMV) Only** - PCR Analysis (LIS)

ORDERING PROVIDER

Provider's First and Last Name
Clinic/Hospital/Institution Name
Provider's Street Address
City / Town
State
Zip Code
Provider's Phone Number
Provider's Fax Number

SEND ADDITIONAL COPY OF RESULTS TO (If applicable)

First and Last Name
Clinic/Hospital/Institution Name
Phone Number
Fax Number
Email Address

■ INSTITUTIONAL BILLING

Institution/Organization Name
Billing Account ID/Submitter Code
Contact Phone
Contact Name

PHYSICIAN CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate informed consent for the testing ordered, including a discussion of the benefits and limitations. I confirm that testing is medically necessary and that test results may impact medical management for the patient. Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the informed consent and/or attached letter of medical necessity.

Signature____________________ Date____________________

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