MEDICAL COLLEGE of WISCONSIN
Genomic Sciences & Precision Medicine Center

Precision Medicine Lab
8701 Watertown Plank Road
Milwaukee, WI 53226
phone: 414-955-2550
fax: 414-955-0088
email: GSPMCInfo@mcw.edu

SARS-CoV2 PCR TEST REQUISITION FORM
(For MCW employees only)

PATIENT INFORMATION *(Required)*

Name (Last, First): _____

Medical Record Number: _____

Date of Birth (MM/DD/YYYY): _____

Gender: ☐ Male ☐ Female ☐ Un-/Non-Gendered

Address: _____
APT# **STREET ADDRESS**

CITY **STATE** **ZIPCODE**

Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Unknown ☐ Prefer not to answer

Race:
☐ American Indian or Alaska Native
☐ Asian
☐ African American
☐ Native Hawaiian or other Pacific Islander
☐ Caucasian
☐ Other _____
☐ Unknown
☐ Prefer not to answer

CLINICAL INFORMATION *(Optional)*

Patient has ever had or received:

☐ **Angiotensin Inhibitors**

☐ **Allogenic Bone Marrow Transplantation**

☐ **Blood transfusion** ☐ YES ☐ NO
If Yes, Date of last blood transfusion: _____

☐ Cardiovascular	
☐ Hypertension	
☐ Type II Diabetes	
☐ Kidney Disease	
☐ Neurological Disorder	

TESTING INFORMATION *(Required)*

Test Requested: ☒ *SARS-CoV-2 virus detection (qRT-PCR)*

Has the individual had prior COVID-19 PCR testing? ☐ *YES* ☐ *NO*

***If YES please note result here:** _____
Please provide a copy of the positive test result

Affected: ☐ Yes ☐ No ☐ Unknown

Turn-Around Time: ☒ Routine ☐ STAT

ORDERING PROVIDER INFORMATION *(Required)*

Ann Nattinger, MD, MPH, MACP — Name of Ordering Provider
1598717266 — NPI#
Medical College of Wisconsin — Hospital, Institution, Practice
8701 Watertown Plank Road — Street Address
Milwaukee, WI, 53226-0509 — City, State, Zip Code
414-955-8495 — Phone
414-955-6565 — FAX
anattinger@mcw.edu — Email
Signature on file — SIGNATURE

FOR LABORATORY USE ONLY

☐ Specimen Intact (acceptable)
☐ Type of test specimen selected
☐ Clinical Information Received (If patient specimen)
☐ Positive Results included (*if required*)
☐ Affected Status Completed
☐ Informed Consent Signed

Comments:

SPECIMEN INFORMATION *(required)*

- **All samples must be labeled with at least two unique identifiers**
- **Patient samples should include name and date of birth**

	Specimen Type	Shipping Temperature	Container	Specimen Requirements
☐	Nasopharyngeal swab Anterior Nasal Swabs	4^0C (on ice)	Collection should use a flocked or spun polyester swab stored in Universal Transport Medium (UTM)	Minimum 1.5mL of UTM containing swab, received within 72hrs of collection

PATIENT CONSENT *(Check all that apply)*

☐ I have received appropriate explanations about this molecular genetic test and all my questions have been answered. I give permission to the Precision Medicine Laboratory at the Medical College of Wisconsin (MCW) to perform the requested test.

☐ I give permission to the laboratory for my specimen and clinical information to be used in quality assurance activities at MCW to improve genetic testing. My name and other personal information will not be used or linked to such activities.

Patient Signature _____ Date _____