



Collaborative Genomics Core
UNIVERSITY OF WISCONSIN-MADISON

University of Wisconsin
Collaborative Genomics Core
465 Henry Mall
Madison, WI 53706-1578
http://www.med.wisc.edu/uwcgc

Infectious Disease (011/2015)

CGC# 134

(PLEASE PRINT USING CAPITALS- FIELDS IN RED ARE REQUIRED)

(1) Patient Last Name		First Name		Middle Name		
(2) Name Change- Former Last Name						
(3) Patient Address						
(4) City		State		Zip		(13) ADDITIONAL REPORT COPIES NEEDED? Please check this box <input type="checkbox"/> AND Enter the clinician's name and address on the back of this form
County of Residence						
(5) Date of Birth		(6) Age		(7) Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		(14) Ordering Provider
(8) Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino		(9) <input type="checkbox"/> Amer Indian <input type="checkbox"/> Asian <input type="checkbox"/> Other _____		<input type="checkbox"/> Black/African Amer <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White		
(10) Chart #/ Patient ID Number		(11) Submitter Specimen ID Number				(15) NPI # _____
(16) Attached copies of front and back of insurance card(s)?			(17) Medicare generally does not cover routine screening tests. ABN attached? <input type="checkbox"/> YES <input type="checkbox"/> NO			
(18) <input type="checkbox"/> MEDICAID# _____		<input type="checkbox"/> PRIVATE INSURANCE# _____		<input type="checkbox"/> MEDICARE# _____		<input type="checkbox"/> Bill to Submitter
(20) Please write the letter corresponding to the appropriate ICD-10 Code to the left of the test name below (where applicable)						
(A) ICD-10 Code _____		(B) ICD-10 Code _____		(C) ICD-10 Code _____		(D) ICD-10 Code _____ (E) ICD-10 Code _____
(21) Date of collection		(22) Time of collection				
Specimen Source <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Blood <input type="checkbox"/> Tumor/Lymph Node (tissue type _____)						
<input type="checkbox"/> Paraffin Section (tissue type _____) Fixative Used: _____ Fixation Time: <input type="checkbox"/> <6 hours <input type="checkbox"/> 6 - 48hrs <input type="checkbox"/> >48 hrs						
Reason for Referral (please provide in addition to ICD-10 code):						

Check All That Apply

- Quantitative HIV-1 by PCR [HIVRNA]
- Quantitative HCV by PCR [HCVRNA]
- Quantitative HBV by PCR [HBVDNA]
- HCV Genotyping [HCVGEN]
- Qualitative CMV by PCR [CMVT, CMVCF, CMVBAL, CMVBF]
- Quantitative CMV, Blood by PCR [CMVDNA]
- Quantitative Polyoma BKV by PCR (Blood [BKVPCR]/ Urine [BKPCR])
- Qualitative HSV I and II by PCR [HSVPCR]
- Qualitative VZV by PCR [VZVPCR]
- Qualitative EBV by PCR [EBVT, CFEBV, BEBV, EBVBAL]
- Quantitative EBV, Blood [EBVPCR]
- Qualitative HPV High Risk [HPVDNA]
- Qualitative HPV 16,18 Genotyping [HPVGEN]
- Bacterial ID by 16s [BID16S]
- IL28b Genotyping [IL28B]