WISCONSIN DIAGNOSTIC LABORATORIES

Client Fax #: _____

Requestor: _____

ADD-ON LAB TEST REQUEST FORM

Wisconsin Diagnostic Laboratories
9200 W. Wisconsin Avenue
Milwaukee, WI 53226

Patient Name:		Date of Birth:	
Client Name:		Physician Name:	
Requisition #:		Phone or Pager #:	
Date/Time of Collection:		Date/Time of Request:	
Accession #:		Request Taken By:	
Financial #:		ICD 10:	

Test(s) Requested: _____

Cytology/PAP: Specimen Source (required): ☐ Endocervix ☐ Ectocervix ☐ Vagina

Clinical Information: _____

Collected With: ☐ Cytobrush ☐ Spatula ☐ Other

To the Ordering Physician or Authorized Agent of the Physician:

In order to comply with the Clinical Laboratory Improvement Amendment of 1988 (CLIA'88), we must obtain written authorization for verbal test request within 30 days.

Please sign, indicating that you did authorize the above test(s). If this form is not returned to us signed within the 30 days, you may be billed for the above test(s).

Please note, if the patient has Medicare, and the test(s) ordered are Limited Coverage and Medicare denies payment due to Medical Necessity, the client may be billed.

Signature: _____ Date: _____

Please fax the signed form to Wisconsin Diagnostic Laboratories Client Services at 414.805.7639 (toll-free outside Milwaukee 1.888.805.7427) or put in an envelope marked Client Services and send to the lab with your specimens or mail to Client Services at the above address.

Thank you.

Comments/Notes: _____