



Ship Specimens to:
 Wisconsin Diagnostic Laboratories
 ATTN: PASS Rm L29
 8777 W. Connell Avenue
 Milwaukee, WI 53226
 Client Services: (414) 805-7600
 wisconsindiagnostic.com

RUBELLA IHC REQUEST FORM

WDL AP HOUSE ACCT. #2400

PATIENT INFORMATION

Patient's Name DOB (mm/dd/yyyy) Sex

Clinical Information / Reason for Consultation (can be provided separately)

- See Attached Letter Copy of Prelim/Final Pathology Report (REQUIRED)

SUBMITTING PROVIDER INFORMATION *(*use assigned client # otherwise use AP House Acct. #2400 if no number/submitter)*

Practice / Institution Name	<input type="text"/>	Client Number *	<input type="text"/>
Ordering Physician	<input type="text"/>	NPI	<input type="text"/>
Address	<input type="text"/>	Phone Number	<input type="text"/>
Email	<input type="text"/>	Fax Number	<input type="text"/>

CLIENT BILLING INFORMATION

Bill To: Client / Institution Same Address as Above (if billing address is different, write in below)

Billing Address	<input type="text"/>	Phone Number	<input type="text"/>
Email	<input type="text"/>	Fax Number	<input type="text"/>

RUBELLA IHC STAIN INFORMATION

Test Name	CPT Code	Pricing
<input checked="" type="checkbox"/> Rubella IHC Stain (w/ Reflex if NEG)	88342 (First) / 88341 (Addl.)	\$131.00

MATERIALS SUBMITTED / SPECIMEN INFORMATION

Body Site	<input type="text"/>	Accession #	<input type="text"/>	Specimen ID #	<input type="text"/>
# of Unstained Slides	<input type="text"/>	# of Stained Slides	<input type="text"/>	# of Blocks	<input type="text"/>
Collection Date	<input type="text"/>	Other	<input type="text"/>		

By signing this form, I certify that the test(s) requested are medically necessary and properly documented in the patient's medical record. I agree that Wisconsin Diagnostic Laboratories (WDL) will issue a monthly itemized invoice with payment due within 30 days.

Ordering Provider's
Signature

Date Time

WDL CLIA#: 52D0391886
 MCW DERM / EM CLIA#: 52D0720169