

Requisition Form: PlexCMV™

Patient Name:

Date of Birth:

Gender: ☐ Male ☐ Female

Insurance Details:

Carrier:

Plan Name:

Member ID#:

Group ID#:

Additional Comments, if any:

Sample Collection Date:

Time: ☐ AM ☐ PM

Sample Volume: ☐ 3ml ☐ Other
(Samples less than 3 ml may be discarded because results may be inaccurate).

Sample Container:

Sodium Heparin (green top) ☐

Shipping Conditions:

Ambient Temperature ☐

Shipping time (from phlebotomy to delivery)

☐ <30 hours ☐ >30 hours

Physician Ordering Test:

NPI #:

Facility:

Facility Phone :

Facility Fax :

Ship to: Plexision, 4424 Penn Avenue, Suite 202, Medical Building, Pittsburgh, PA 15224
Phone: 1(855)-753-9474 or 1(855)-PLEXISION; Fax: 412-224-2776