

	HIV ANALYSIS PUBLIC HEALTH LABORATORY TEST REQUEST	FOR LAB USE ONLY
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Please print clearly: DATE * (MM/DD/YYYY): ***Required information**

1. PATIENT INFORMATION			
PATIENT LAST NAME *:		PATIENT FIRST NAME *:	
<input style="width: 90%;" type="text"/>		<input style="width: 90%;" type="text"/>	
DATE OF BIRTH * (MM/DD/YYYY):	Sex *:	PATIENT ID#/MEDICAL RECORD#:	
<input style="width: 150px;" type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	<input style="width: 150px;" type="text"/>	
ADDRESS:	CITY:	STATE:	ZIP:
<input style="width: 150px;" type="text"/>	<input style="width: 150px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>
TELEPHONE:	PHYSICIAN: (if other than submitter)	Pager/Cell:	
<input style="width: 150px;" type="text"/>	<input style="width: 150px;" type="text"/>	<input style="width: 150px;" type="text"/>	

2. SUBMITTER INFORMATION			
NAME OF SUBMITTING HOSPITAL, LABORATORY, or OTHER FACILITY Etc. *:		PROVIDER ID#/NYS LICENSE#:	
<input style="width: 90%;" type="text"/>		<input style="width: 90%;" type="text"/>	
PRIMARY CONTACT or PHYSICIAN- LAST NAME *:		FIRST NAME *:	
<input style="width: 90%;" type="text"/>		<input style="width: 90%;" type="text"/>	
ADDRESS *:			
<input style="width: 95%;" type="text"/>			
CITY *:	STATE *:	ZIP *:	
<input style="width: 150px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	
TELEPHONE *:	Pager/Cell *:	Fax:	EMAIL:
<input style="width: 150px;" type="text"/>	<input style="width: 150px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 100px;" type="text"/>

3. SPECIMEN INFORMATION			
DATE OF COLLECTION * (MM/DD/YYYY):		TIME OF COLLECTION * (where applicable): [00:00] <input type="checkbox"/> AM <input type="checkbox"/> PM	
<input style="width: 150px;" type="text"/>		<input style="width: 150px;" type="text"/>	
Reason for submission *	<input type="checkbox"/> DIAGNOSTIC <input type="checkbox"/> CONFIRMATORY <input type="checkbox"/> OUTBREAK <input type="checkbox"/> DOHMH REQUEST (if checked complete A & B below)		
A. DOHMH bureau	<input type="checkbox"/> BCD <input type="checkbox"/> BSTD <input type="checkbox"/> OTHER (specify):		DOHMH EVENT CODE:
	<input style="width: 150px;" type="text"/>		<input style="width: 100px;" type="text"/>
B. DOHMH contact	Last Name:	First Name:	
	<input style="width: 150px;" type="text"/>	<input style="width: 150px;" type="text"/>	
Specimen type *	<input type="checkbox"/> Serum <input type="checkbox"/> Plasma <input type="checkbox"/> Whole Blood <input type="checkbox"/> Other (specify type):		
	<input style="width: 150px;" type="text"/>		
Additional testing information *	HIV Vaccine Recipient <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
	Other Immunization/Viral Infections within the last 3 months: <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes (specify):		
	<input style="width: 150px;" type="text"/>		
RISK FACTORS * (answer all items)	Males who have sex with Males:		Sex Partner of Injecting Drug User:
	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN		<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN
	Injecting Drug User:		Sex Partner of Person with Other HIV/AIDS Risk:
	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN		<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN
	Blood Product Recipient:	Child of Woman with HIV/AIDS:	
	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN	
	Occupational Exposure (specify):	Date of Last Negative HIV Test (specify):	
	<input style="width: 150px;" type="text"/>	<input style="width: 150px;" type="text"/>	

ADDITIONAL INFORMATION *			
Race/Ethnicity:			
<input type="checkbox"/> White, Non-Hispanic <input type="checkbox"/> Black, Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific. Isl. <input type="checkbox"/> Native American <input type="checkbox"/> Alaskan <input type="checkbox"/> Other (specify):			
<input style="width: 150px;" type="text"/>			
Area of Birth: <input type="checkbox"/> Africa <input type="checkbox"/> Asia <input type="checkbox"/> Caribbean <input type="checkbox"/> Central America <input type="checkbox"/> Europe <input type="checkbox"/> Middle East <input type="checkbox"/> North America <input type="checkbox"/> South America			
Length of Residency in U.S. <input style="width: 50px;" type="text"/> Years <input style="width: 50px;" type="text"/> Mos.			
Residence Outside the U.S. (3 MOS. or longer): <input type="checkbox"/> No <input type="checkbox"/> Yes (specify):			
<input style="width: 150px;" type="text"/>			

4. TEST(S) REQUESTED *	
<input type="checkbox"/> HIV Antibody	<input type="checkbox"/> Other (specify):
<input style="width: 150px;" type="text"/>	<input style="width: 150px;" type="text"/>

SUBMITTER ATTESTATION STATEMENT: I certify that the patient has received information about limitations, risks and the voluntary nature of the test, has received pre-test counseling, has signed an informed consent form, will received post-test counseling, and has been informed that if positive, his/her name will be reported to the NYS and NYC Departments of Health.

Submitter signature: *

*Failure to provide the required information or any discrepancy relating to the specimen submitted, may result in an inability to test or a delay in the release of test results.