Virology Section-NYC DOHMH
455 First Avenue, New York, NY 10016
TEL (212) 447 2864 FAX (212) 447 2877

NYC Health

HIV ANALYSIS

PUBLIC HEALTH LABORATORY TEST REQUEST

FOR LAB USE ONLY

Please print clearly: DATE* (MM/DD/YYYY): :

*Required information

1. PATIENT INFORMATION

PATIENT LAST NAME*:

PATIENT FIRST NAME*:

DATE OF BIRTH* (MM/DD/YYYY):

Sex*: ☐ Male ☐ Female ☐ Unknown

PATIENT ID#/MEDICAL RECORD#:

ADDRESS:

CITY:

STATE:

ZIP:

TELEPHONE: EXT.

PHYSICIAN: (if other than submitter)

Pager/Cell:

2. SUBMITTER INFORMATION

NAME OF SUBMITTING HOSPITAL, LABORATORY, or OTHER FACILITY Etc.*:

PROVIDER ID#/NYS LICENSE#:

PRIMARY CONTACT or PHYSICIAN- LAST NAME*:

FIRST NAME*:

ADDRESS*:

CITY*:

STATE*:

ZIP*:

TELEPHONE*: EXT.

Pager/Cell*:

Fax:

EMAIL:

3. SPECIMEN INFORMATION

DATE OF COLLECTION* (MM/DD/YYYY):

TIME OF COLLECTION* (where applicable): [00:00] ☐ AM ☐ PM

Reason for submission* ☐ DIAGNOSTIC ☐ CONFIRMATORY ☐ OUTBREAK ☐ DOHMH REQUEST **(if checked complete A & B below)**

A. DOHMH bureau ☐ BCD ☐ BSTD ☐ OTHER (specify): DOHMH EVENT CODE:

B. DOHMH contact Last Name: First Name:

Specimen type* ☐ Serum ☐ Plasma ☐ Whole Blood ☐ Other (specify type):

Additional testing information*

HIV Vaccine Recipient ☐ Yes ☐ No ☐ Unknown

Other Immunization/Viral Infections within the last 3 months: ☐ No ☐ Unknown ☐ Yes (specify):

RISK FACTORS* (answer all items)

Males who have sex with Males: ○ YES ○ NO ○ UNKNOWN

Sex Partner of Injecting Drug User: ○ YES ○ NO ○ UNKNOWN

Injecting Drug User: ○ YES ○ NO ○ UNKNOWN

Sex Partner of Person with Other HIV/AIDS Risk: ○ YES ○ NO ○ UNKNOWN

Blood Product Recipient: ○ YES ○ NO ○ UNKNOWN

Child of Woman with HIV/AIDS: ○ YES ○ NO ○ UNKNOWN

Occupational Exposure (specify):

Date of Last Negative HIV Test (specify):

ADDITIONAL INFORMATION*

Race/Ethnicity: ☐ White, Non-Hispanic ☐ Black, Non-Hispanic ☐ Hispanic ☐ Asian/Pacific. Isl. ☐ Native American ☐ Alaskan ☐ Other (specify):

Area of Birth: ☐ Africa ☐ Asia ☐ Caribbean ☐ Central America ☐ Europe ☐ Middle East ☐ North America ☐ South America

Length of Residency in U.S. Years Mos.

Residence Outside the U.S. (3 MOS. or longer): ☐ No ☐ Yes (specify):

4. TEST(S) REQUESTED*

☐ HIV Antibody

☐ Other (specify):

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:*

LTR_DVI04F_0909

*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.