



New York City Department of Health and Mental Hygiene
PUBLIC HEALTH LABORATORY
Jennifer Rakeman, Ph.D., Assistant Commissioner
 455 First Avenue, New York, NY 10016
 NYS CLEP PERMIT #: PFI 3849 CLIA #: 33D0679872

PHL USE ONLY

HIV LABORATORY TEST REQUEST
 Virology Section: Tel 212.447-2864 Fax 212.447-2877

PATIENT INFORMATION

***Required Information**

LAST NAME*		FIRST NAME*		MIDDLE INITIAL	SUFFIX
DATE OF BIRTH* (MM/DD/YYYY)		GENDER* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender F → M <input type="checkbox"/> Transgender M → F			
RACE <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other		ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown			
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					
COUNTRY OF BIRTH (specify):					
PATIENT ID NUMBER		PATIENT MEDICAL RECORD NUMBER*		PATIENT PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
ADDRESS*		CITY*		STATE*	ZIP*
TELEPHONE		PHYSICIAN (if not submitter, incl. contact info.)			

SUBMITTER INFORMATION

NAME OF SUBMITTING HOSPITAL, LABORATORY, or OTHER FACILITY*		PROVIDER ID #			
PRIMARY CONTACT* LAST NAME or PHYSICIAN*		FIRST NAME			
ADDRESS (incl. bldg. and room)*		CITY*	STATE*	ZIP*	
TELEPHONE*	PAGER/CELL*	FAX	EMAIL		

SPECIMEN INFORMATION

DATE OF COLLECTION * (MM/DD/YYYY)		TIME OF COLLECTION (00:00) <input type="checkbox"/> AM <input type="checkbox"/> PM			
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"/> BSTDC <input type="checkbox"/> OTHER (specify):		DOHMH INVESTIGATION CODE			
B. DOHMH CONTACT (LAST NAME, FIRST NAME)					
SPECIMEN TYPE* <input type="checkbox"/> Serum <input type="checkbox"/> Plasma <input type="checkbox"/> Whole blood <input type="checkbox"/> Cadaveric fluid					
Additional comments/Clinical syndrome, Exposure/Travel History:					

RISK FACTORS*

Male who has sex with male(s): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Injecting drug user: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Sex partner of injecting drug user: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Sex partner of person with other HIV/AIDS risk: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Blood product recipient: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Child of woman with HIV/AIDS: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Occupational exposure: <input type="checkbox"/> Yes (specify) <input type="checkbox"/> No <input type="checkbox"/> Unknown		Date of last negative HIV test (MM/DD/YYYY):			
Additional testing Information*	Current diagnosis:		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"/> Yes (specify) <input type="checkbox"/> No <input type="checkbox"/> Unknown				
	Length of residency in US Years: Mos:		Residency outside US (≥ 3 mos): <input type="checkbox"/> Yes (specify) <input type="checkbox"/> No		
Additional Comments:					

TEST REQUESTED

<input type="checkbox"/> HIV Screening	<input type="checkbox"/> Other (specify):
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