LAB 21

Virology Services Test Request Form

PATIENT DETAILS

Affix patient label here

* Patient ID(MRN/NHS No)	
* Hospital/Clinic No	
ID 3	
*Date of Birth	
Gender	☐ Male ☐ Female

Please note that fields marked with * are compulsory.

At least 3 unique patient identifiers must be included on samples and request form.

*TEST(S) REQUESTED

EDTA PLASMA

HIV-1 PR-RT Resistance	>2ml Plasma	☐
HIV-1 Integrase Resistance	>2ml Plasma	☐
Viral RNA HIV-1 V3 Tropism by Genotype *Use for samples with HIV VL >500 copies/ml*	>2ml Plasma	☐
HIV-1 Viral Load	>2ml Plasma	☐

*Sample collection date (e.g. 01 JAN 2014)

EDTA WHOLE BLOOD

Proviral DNA HIV-1 V3 Tropism by Genotype *Use for samples with HIV VL <500 copies/ml*	>2ml EDTA Whole Blood	☐
HLA B*57:01	>2ml EDTA Whole Blood	☐

*Sample collection date (e.g. 01 JAN 2014)

Previous HIV-1 Viral Load ____ copies/ml Date of result: ____

CLINICAL CENTRE INFORMATION

If you do not know your customer DD Code please contact Lab 21 for assistance.

*Customer number	DD	Tel	
*Address		Fax	
		*Email	
		*Contact	
*Postcode			

REQUESTING HEALTH PROFESSIONAL

*Name (BLOCK CAPITALS)	
Date	
Comments	

FINANCE DETAILS

Please provide any finance authorisation details we may require when invoicing.

PO Number	
Cost Centre	
Budget Holder	

Lab21 USE ONLY ID No ..... Date..... Entered by..... Validated by.....

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