LAB 21

Virology Services Test Request Form

PATIENT DETAILS

Please note that fields marked with * are compulsory.

Affix patient label here

* ID 1
* ID 2
ID 3
*Date of Birth
Gender ☐ Male ☐ Female

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

*TEST(S) REQUESTED

EDTA PLASMA

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

*Sample collection date (e.g DD MMM YYYY)

EDTA WHOLE BLOOD

Test	Sample	
HLA-B*57:01 genotyping	>2ml EDTA Whole Blood	☐

*Sample collection date (e.g. DD MMM YYYY)

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.

*Lab21 Account Number DD
*Address
*Postcode
Tel
Fax
*Email
*Contact

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..................................