

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	
HIV-1 PR-RT Resistance	>2ml Plasma <input type="checkbox"/>
HIV-1 Integrase Resistance	>2ml Plasma <input type="checkbox"/>
Viral RNA HIV-1 V3 Tropism by Genotype <i>Use for samples with HIV VL >500 copies/ml</i>	>2ml Plasma <input type="checkbox"/>
*Sample collection date (e.g DD MMM YYYY)	<input type="text"/>

EDTA WHOLE BLOOD	
Proviral DNA HIV-1 V3 Tropism by Genotype <i>Use for samples with HIV VL <500 copies/ml</i>	>2ml EDTA Whole Blood <input type="checkbox"/>
HLA-B*57:01 genotyping	>2ml EDTA Whole Blood <input type="checkbox"/>
*Sample collection date (e.g. DD MMM YYYY)	<input type="text"/>

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	<input type="text" value="DD"/>	Tel	<input type="text"/>
*Address	<input type="text"/>	Fax	<input type="text"/>
*Postcode	<input type="text"/>	*Email	<input type="text"/>
		*Contact	<input type="text"/>

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.....