



OLS USE ONLY

DIAGNOSTIC IMMUNOLOGY LABORATORY SPECIMEN SUBMISSION FORM

PATIENT INFORMATION

PATIENT ID (Chart #, etc.) <i>(optional)</i>		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# (last 4 digits only)	
COUNTY OF RESIDENCE	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	
STREET ADDRESS		
CITY	STATE	ZIP
PATIENT PHONE NO. (include area code)		
RACE <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Native Hawaiian or other Pacific Islander	ETHNICITY <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unknown	
PATIENT TYPE (for Hepatitis Testing only) <input type="checkbox"/> Employee <input type="checkbox"/> Medically Indigent <input type="checkbox"/> Patient <input type="checkbox"/> Investigation		
		CLINIC #

SUBMITTER INFORMATION

FACILITY NAME		
MAILING ADDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO:		
PHONE NO. (include area code)		
FAX NO. (include area code)		

I have been advised of the implications of the HIV Antibody test and have been given an opportunity to ask questions and have my questions answered.

HIV Consent for Testing (signature)

CTR Counselor Witness (signature)

OLS USE ONLY	ACC:
<input type="checkbox"/> UNSAT	DE:
Reason/ID:	CKD:

USE ONE FORM PER SPECIMEN

DATE OF COLLECTION:	
Program Type (Select ONE Only):	
<input type="checkbox"/> APC (For anonymous HIV testing only)	<input type="checkbox"/> HIV Clinic
<input type="checkbox"/> College / University -FP	<input type="checkbox"/> Jail / Prison
<input type="checkbox"/> College / University -STD	<input type="checkbox"/> Juvenile Detention Center
<input type="checkbox"/> Family Planning	<input type="checkbox"/> Project # _____
<input type="checkbox"/> Fee for Service	<input type="checkbox"/> STD Clinic/STD Services
<input type="checkbox"/> Hospital	<input type="checkbox"/> TB Clinic
TEST REQUESTED (Select ONE Only):	
<input type="checkbox"/> Hepatitis A IgM (Approval required from Program)	<input type="checkbox"/> Rubella Screen
<input type="checkbox"/> Hepatitis B Screen	<input type="checkbox"/> Syphilis Screen (RPR)
<input type="checkbox"/> Hepatitis C Antibody	<input type="checkbox"/> CT/GC Amplified (urine) / NAAT
<input type="checkbox"/> Hepatitis Post-Vac (HBsAb) FEE FOR SERVICE	<input type="checkbox"/> HIV
	<input type="checkbox"/> Orasure WB (for Rapid HIV Program Only)
SOURCE OF SPECIMEN:	
<input type="checkbox"/> Blood / Serum	<input type="checkbox"/> Urine
<input type="checkbox"/> Oral fluid	
CT/GC INFORMATION - REASON FOR TEST (as per guidelines)	
<input type="checkbox"/> Any symptom of STD	<input type="checkbox"/> Re-screen of previous positive
<input type="checkbox"/> Known contact to STD	<input type="checkbox"/> Suspect contact to STD
<input type="checkbox"/> IUD Insertion	
HEPATITIS INFORMATION -RISK FACTORS (R. F.)	
<p>For Hepatitis B testing - patient must have at least one of the bolded risk factors to be eligible for Hepatitis B testing. Then mark all risk factors for hepatitis B. All R.F. should have occurred within the past 12 months. For Hepatitis C testing- mark if patient EVER had a history of any of the listed risk factors. One form for Hepatitis B and One form for Hepatitis C</p>	
<input type="checkbox"/> BODY PIERCING (NON-COMMERCIAL)	<input type="checkbox"/> MULTIPLE PARTNERS
<input type="checkbox"/> IV DRUG USER	<input type="checkbox"/> TATTOO (NON-COMMERCIAL)
<input type="checkbox"/> Blood transfusions	<input type="checkbox"/> Illicit non-IV drug use
<input type="checkbox"/> Healthcare worker	<input type="checkbox"/> Needle stick/blood splash
<input type="checkbox"/> Hemodialysis	<input type="checkbox"/> Pregnant (due date _____)
<input type="checkbox"/> History of incarceration	<input type="checkbox"/> Sexual contact
<input type="checkbox"/> Household contact	<input type="checkbox"/> Symptoms / Diagnosis of STD
HIV INFORMATION (Select all that apply)	
RISK FACTORS	HETEROSEXUAL RELATIONS WITH
<input type="checkbox"/> Sex with male	<input type="checkbox"/> IV injection drug user
<input type="checkbox"/> Sex with female	<input type="checkbox"/> Bisexual male
<input type="checkbox"/> Injected non-Rx drugs	<input type="checkbox"/> Person with hemophilia/clotting disorder
<input type="checkbox"/> Rec'd Clotting Factor F VIII A	<input type="checkbox"/> Transfusion recipient WITH documented HIV positive
<input type="checkbox"/> Rec'd Clotting Factor F IX B	<input type="checkbox"/> Transplant WITH documented HIV positive
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Person with AIDS or documented HIV positive
<input type="checkbox"/> Rec'd transplant or artificial insemination	<input type="checkbox"/> Unspecified risk
<input type="checkbox"/> Healthcare worker / lab worker	
<input type="checkbox"/> Pregnant (due date _____)	
PLACE HIV TEST FORM BARCODE LABEL HERE	