

Clinical Test Request Form

TEST REQUESTED:	SPECIMEN REQUIREMENT:	DRAW TUBE:
<input type="checkbox"/> HIV-1 ELISA & Western Blot	serum or plasma (room temp.)	SST/EDTA
<input type="checkbox"/> HIV-2 ELISA	serum or plasma (room temp.)	SST/EDTA
<input type="checkbox"/> HTLV-I/II ELISA	serum or plasma (room temp.)	SST/EDTA
<input type="checkbox"/> Hepatitis C RIBA 3.0	serum or plasma (room temp.)	SST/K3 EDTA
<i>Initial result s/co:</i> _____		

<input type="checkbox"/> Roche HIV-1 Monitor Test V 1.5	(Viral Load) (frozen)	PPT/EDTA
<input type="checkbox"/> STANDARD	<input type="checkbox"/> ULTRA SENSITIVE	
<input type="checkbox"/> HIV-1 Resistance Genotyping	plasma (frozen)	EDTA/ACD/PPT
<i>Viral Load Date (dd/mm/yyyy):</i> _____ <i>Result:</i> _____ <i>Copies/ml</i> (Within the previous 30 days)		
<input type="checkbox"/> HIV-1 Phenotype	plasma (frozen)	EDTA/ACD/PPT
<i>Viral Load Date (dd/mm/yyyy):</i> _____ <i>Result:</i> _____ <i>Copies/ml</i> (Within the previous 30 days)		
<i>Current Therapeutic Regiment:</i> _____		

The following needs pre-approval. Contact Flow Lab Supervisor @ 301-251-5045.

<input type="checkbox"/> Flow Cytometric Immunophenotype	whole blood (room temp. anticoagulated)	HEP/EDTA
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PATIENT STATUS		
<input type="checkbox"/> Sponsor	<input type="checkbox"/> Dependent	<input type="checkbox"/> Civilian

PATIENT IDENTIFICATION	CONTACT INFORMATION
Patient Stamp <u>Must include:</u> Full Name*, FMP*/SSN*, and DOB* Specimen Draw Date & Time* _____	POC* _____ Physician Name* _____ Clinic/ Center* _____ Telephone Number _____ FAX Number _____ (Commercial # only, please include area/ country code) Alternate POC _____ Center Address* _____ _____

PROCESSING LAB (For internal use only):		
BARCODE	DATE RECEIVED	QUANTITY &TYPE RECEIVED/ INITIALS

*Required