HIV DIAGNOSTICS AND REFERENCE LABORATORY

13 Taft Ct. ☐ Suite 100 ☐ Rockville, MD 20850

HIV Verification Algorithm Test Request Form

TESTS	SPECIMEN REQUIREMENT	DRAW TUBE
☐ **HIV Algorithm**	4 ml plasma (Cold Pack)	PPT

SHIP FROZEN PLASMA IF SAMPLE WILL NOT BE RECEIVED AT HDRL WITHIN 72 HOURS.

PATIENT IDENTIFICATION	CONTACT INFORMATION
Patient Stamp must include: Full Name*, FMP*/SSN*, DOB*	**POC*** _____
	Physician Name* _____
	Clinic / Center* _____
	Center Address* _____
	_____
	_____
	_____
	Telephone Number _____
	Fax Number _____
Specimen Draw Date / Time*: _____	(Commercial # only; please include area/country code)
Ship Date: _____	Alternate POC Name _____
Sample Storage (circle): **Frozen / Refrig / Ambient**	Alternate POC Phone _____
Sample Shipping (circle): **Dry Ice / Cold Pack**	

***Required**

PROCESSING LAB (For internal use only)

BARCODE	DATE RECEIVED	QUANTITY & TYPE RECEIVED/INITIALS

TUBES DRAWN	SPECIMEN REQUIREMENT	INSTRUCTIONS
☐ **4 PPT s**	Aliquot PPL into NINE (9) cryovials - 2, 1.0 mL each - 2, 0.5 mL each - 1, 2mL - 2, 1.20 mL each - 1, 2 mL - 2, remaining volume	Freeze at -80°C or lower Forward one vial of plasma at 1 ml to HDRL for confirmatory testing
☐ **2 CPTs**	Collect Cell Pellets and store into SEVEN (7) cryovials - 2, 5 million cells each - 5, 1 million cells each	Freeze at -80°C or lower