

	<b>HIV ANALYSIS</b> <b>PUBLIC HEALTH LABORATORY TEST REQUEST</b>	FOR LAB USE ONLY
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**Please print clearly:** DATE \* (MM/DD/YYYY):  **\*Required information**

<b>1. PATIENT INFORMATION</b>			
PATIENT LAST NAME *:		PATIENT FIRST NAME *:	
<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>	
DATE OF BIRTH * (MM/DD/YYYY):	Sex *:	PATIENT ID#/MEDICAL RECORD#:	
<input style="width: 150px;" type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	<input style="width: 150px;" type="text"/>	
ADDRESS:	CITY:	STATE:	ZIP:
<input style="width: 150px;" type="text"/>	<input style="width: 150px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>
TELEPHONE:	PHYSICIAN: (if other than submitter)	Pager/Cell:	
<input style="width: 150px;" type="text"/>	<input style="width: 150px;" type="text"/>	<input style="width: 150px;" type="text"/>	

<b>2. SUBMITTER INFORMATION</b>			
NAME OF SUBMITTING HOSPITAL, LABORATORY, or OTHER FACILITY Etc. *:		PROVIDER ID#/NYS LICENSE#:	
<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>	
PRIMARY CONTACT or PHYSICIAN- LAST NAME *:		FIRST NAME *:	
<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>	
ADDRESS *:			
<input style="width: 100%;" type="text"/>			
CITY *:	STATE *:	ZIP *:	
<input style="width: 150px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	
TELEPHONE *:	Pager/Cell *:	Fax:	EMAIL:
<input style="width: 150px;" type="text"/>	<input style="width: 150px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 100px;" type="text"/>

<b>3. SPECIMEN INFORMATION</b>			
DATE OF COLLECTION * (MM/DD/YYYY):		TIME OF COLLECTION * (where applicable): [00:00] AM PM	
<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>	
Reason for submission *	<input type="checkbox"/> DIAGNOSTIC <input type="checkbox"/> CONFIRMATORY <input type="checkbox"/> OUTBREAK <input type="checkbox"/> DOHMH REQUEST (if checked complete A & B below)		
A. DOHMH bureau	<input type="checkbox"/> BCD <input type="checkbox"/> BSTD <input type="checkbox"/> OTHER (specify): <input style="width: 100px;" type="text"/>		DOHMH EVENT CODE: <input style="width: 100px;" type="text"/>
B. DOHMH contact	Last Name: <input style="width: 100px;" type="text"/>	First Name: <input style="width: 100px;" type="text"/>	
Specimen type *	<input type="checkbox"/> Serum <input type="checkbox"/> Plasma <input type="checkbox"/> Whole Blood <input type="checkbox"/> Other (specify type): <input style="width: 100px;" type="text"/>		
Additional testing information *	HIV Vaccine Recipient <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
	Other Immunization/Viral Infections within the last 3 months: <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes (specify): <input style="width: 100px;" type="text"/>		
RISK FACTORS * (answer all items)	Males who have sex with Males:		Sex Partner of Injecting Drug User:
	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN		<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN
	Injecting Drug User:		Sex Partner of Person with Other HIV/AIDS Risk:
	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN		<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN
Blood Product Recipient:		Child of Woman with HIV/AIDS:	
<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN		<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNKNOWN	
Occupational Exposure (specify): <input style="width: 150px;" type="text"/>		Date of Last Negative HIV Test (specify): <input style="width: 150px;" type="text"/>	

<b>ADDITIONAL INFORMATION *</b>			
Race/Ethnicity:			
<input type="checkbox"/> White, Non-Hispanic <input type="checkbox"/> Black, Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific. Isl. <input type="checkbox"/> Native American <input type="checkbox"/> Alaskan <input type="checkbox"/> Other (specify): <input style="width: 100px;" type="text"/>			
Area of Birth: <input type="checkbox"/> Africa <input type="checkbox"/> Asia <input type="checkbox"/> Caribbean <input type="checkbox"/> Central America <input type="checkbox"/> Europe <input type="checkbox"/> Middle East <input type="checkbox"/> North America <input type="checkbox"/> South America			
Length of Residency in U.S. <input style="width: 50px;" type="text"/> Years <input style="width: 50px;" type="text"/> Mos.			
Residence Outside the U.S. (3 MOS. or longer): <input type="checkbox"/> No <input type="checkbox"/> Yes (specify): <input style="width: 100px;" type="text"/>			

<b>4. TEST(S) REQUESTED *</b>	
<input type="checkbox"/> HIV Antibody	<input type="checkbox"/> Other (specify): <input style="width: 100px;" type="text"/>

**SUBMITTER ATTESTATION STATEMENT:** I certify that the patient has received information about limitations, risks and the voluntary nature of the test, has received pre-test counseling, has signed an informed consent form, will received post-test counseling, and has been informed that if positive, his/her name will be reported to the NYS and NYC Departments of Health.

Submitter signature: \*

\*Failure to provide the required information or any discrepancy relating to the specimen submitted, may result in an inability to test or a delay in the release of test results.