OFFICE OF LABORATORY SERVICES
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OLS USE ONLY

DIAGNOSTIC IMMUNOLOGY LABORATORY SPECIMEN SUBMISSION FORM

PATIENT INFORMATION

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

SUBMITTER INFORMATION

CLINIC #

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)

USE ONE FORM PER SPECIMEN

DATE OF COLLECTION:

CLINIC TYPE (Select ONE Only):	
❑ APC	❑ Jail / Prison
❑ CBO	❑ Juvenile Detention Center
❑ College / University -FP	❑ **Project #** _____
❑ College / University -STD	❑ STD Clinic/STD Services
❑ Family Planning	❑ Substance Abuse Center
❑ Hospital	❑ TB Clinic

TEST REQUESTED (Select ONE Only):	
❑ Hepatitis A IgM	❑ Rubella Screen
❑ Hepatitis B Screen	❑ Syphilis Screen (RPR)
❑ Hepatitis C Antibody	❑ CT/GC Amplified (urine) / NAAT
❑ Hepatitis Post-Vac (HBsAb)	❑ HIV
	❑ Orasure WB **(for Rapid HIV Program Only)**

SOURCE OF SPECIMEN:	
❑ Blood / Serum	❑ Urine
❑ Oral fluid	

CT/GC INFORMATION - REASON FOR TEST (as per guidelines)	
❑ Any symptom of STD	❑ Re-screen of previous positive
❑ Known contact to STD	❑ Suspect contact to STD

HEPATITIS INFORMATION -RISK FACTORS (Select all that apply)	
❑ Anal sex	❑ MSM
❑ Blood transfusions	❑ Multiple partners
❑ Body piercing	❑ Needle stick/blood splash
❑ Healthcare worker	❑ Pregnant (due date _____)
❑ Hemodialysis	❑ Sexual contact
❑ History of incarceration	❑ Symptoms / Diagnosis of STD
❑ Household contact	❑ Tattoo
❑ Illicit non-IV drug use	❑ Unknown
❑ IV drug user	❑ None of the above

HIV INFORMATION (Select all that apply)	
RISK FACTORS	**HETEROSEXUAL RELATIONS WITH**
❑ Sex with male	❑ IV injection drug user
❑ Sex with female	❑ Bisexual male
❑ Injected non-Rx drugs	❑ Person with hemophilia/clotting disorder
❑ Rec'd Clotting Factor F VIII A	❑ Transfusion recipient WITH documented HIV positive
❑ Rec'd Clotting Factor F IX B	❑ Transplant WITH documented HIV positive
❑ Blood transfusion	❑ Person with AIDS or documented HIV positive
❑ Rec'd transplant or artificial insemination	❑ Unspecified risk
❑ Healthcare worker / lab worker	
❑ Pregnant (due date _____)	

OLS USE ONLY	ACC:
❑ UNSAT	DE:
Reason/ID:	CKD:

Place CDC HIV TEST FORM Barcode Label HERE

USE ONE FORM PER SPECIMEN- FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY WILL RESULT IN THE TEST NOT BEING COMPLETED AND ANOTHER SAMPLE WILL BE REQUESTED