Ontario
Agency for Health Protection and Promotion
Public Health Laboratories

Date received PHL No.

HIV Serology Test Requisition

For tests other than HIV & HTLV please use the PHL Test Requisition
Fully Complete sections 1 through 6

1 Patient Information/Addressograph (please print)

Previous Specimen No. Previous Result ☐ Negative ☐ Positive ☐ Indeterminate

Senders Reference No.

Patient Identifier (if coded)

Surname *(per OHIP card)* First Name *(per OHIP card)*

Date of Birth Sex ☐ F ☐ M

2 Physician/Referring Laboratory

WHOLE CLOTTED BLOOD PREFERRED

Appropriate HIV Serology will be carried out according to the information provided above. Reactive screen tests will be confirmed with supplemental testing and western blot. Additional testing (p24 antigen) will be carried out when a patient is suspected of being in the window period or under other specific circumstances.

Complete information is essential for epidemiologic analyses regarding HIV in Ontario. Information is protected by the FOIPPA and the method of patient identification is left to your discretion (Code or nominal). Anonymous testing is also available at 34 designated Ontario sites.

The identification on specimen **must** match the identification on this form.

3 Exposure Category (check all that apply)

- ☐ sex with women
- ☐ sex with men
- ☐ needle use (injecting drugs/steroids)
- ☐ has lived in endemic area[1]
- ☐ blood transfusion pre 1986
- ☐ clotting factor pre 1986
- ☐ child of HIV+ mother
- ☐ needlestick injury
- ☐ heterosexual[2] partner of HIV+ person
- ☐ heterosexual[2] partner of a person at risk of HIV
- ☐ none
- ☐ other (specify)

If applicable - please indicate:

1. Endemic country/region
2. Exposure category of heterosexual partner
   - ☐ IDU
   - ☐ endemic area
   - ☐ transfused
   - ☐ clotting factor
   - ☐ needlestick injury
   - ☐ bisexual male

4 Reason for HIV testing (check all that apply)

☐ Diagnostic ☐ Prenatal ☐ Visa/immigration requirement
☐ Donor of blood/tissue/semen ☐ Follow-up ☐ Insurance

5 Symptoms

- ☐ none
- ☐ suspected acute seroconversion (flu-like illness)

date of onset (if known)

date of exposure (if known)

- ☐ AIDS
- ☐ other HIV related disease
- ☐ other medical conditions (specify)

6 Specimen Details

Collection date of specimen

Type of specimen ☐ whole blood ☐ serum ☐ ACD/EDTA ☐ CSF

Tests requested: ☐ HIV1/HIV2 ☐ HTLVI/HTLVII

Comments

Laboratory Use Only

Specimen priority ☐

Specimen volume ☐

TF ☐

Please print/stamp doctor's address and postal code clearly and firmly

Form No. 1210-44B (01/09)

CONFIDENTIAL WHEN COMPLETED