

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	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Indeterminate
Senders Reference No.				
Patient Identifier (if coded)				
Surname (per OHIP card)			First Name (per OHIP card)	
Date of Birth	yyyy / mm / dd	Sex	<input type="checkbox"/> F	<input type="checkbox"/> M
Place: Addressograph or Patient Label Here				

2 Physician/Referring Laboratory

DR. / RM / RN EC _____	PHY# _____
Provide: Submitter information	
Physician(s) ordering Test	
Agency/Institution	

For tests other than HIV and HTLV, use the PHL test requisition

PLEASE FILL IN THE HIV SEROLOGY REQUISITION COMPLETELY AND ACCURATELY

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)

<input type="checkbox"/> sex with women	<i>If applicable - please indicate:</i>
<input type="checkbox"/> sex with men	
<input type="checkbox"/> needle use (injecting drugs/steroids)	1. Endemic country/region _____
<input type="checkbox"/> has lived in endemic area ¹	
<input type="checkbox"/> blood transfusion pre 1986	
<input type="checkbox"/> clotting factor pre 1986	2. Exposure category of heterosexual partner
<input type="checkbox"/> child of HIV+ mother	<input type="checkbox"/> IDU
<input type="checkbox"/> needlestick injury	<input type="checkbox"/> endemic area
<input type="checkbox"/> heterosexual ² partner of HIV+ person	<input type="checkbox"/> transfused
<input type="checkbox"/> heterosexual ² partner of a person at risk of HIV	<input type="checkbox"/> clotting factor
<input type="checkbox"/> none	<input type="checkbox"/> needlestick injury
<input type="checkbox"/> other (specify) _____	<input type="checkbox"/> bisexual male

4 Reason for HIV testing (check all that apply)

<input type="checkbox"/> Diagnostic	<input type="checkbox"/> Prenatal	<input type="checkbox"/> Visa/immigration requirement
<input type="checkbox"/> Donor of blood/tissue/semen	<input type="checkbox"/> Follow-up	<input type="checkbox"/> Insurance

5 Symptoms

<input type="checkbox"/> none
<input type="checkbox"/> suspected acute seroconversion (flu-like illness)
date of onset (if known) yyyy / mm / dd
date of exposure (if known) yyyy / mm / dd
<input type="checkbox"/> AIDS
<input type="checkbox"/> other HIV related disease
<input type="checkbox"/> other medical conditions (specify) _____

6 Specimen Details

Collection date of specimen	yyyy / mm / dd
Type of specimen	<input type="checkbox"/> whole blood <input type="checkbox"/> serum
	<input type="checkbox"/> ACD/EDTA <input type="checkbox"/> CSF
Tests requested:	<input type="checkbox"/> HIV1/HIV2 <input type="checkbox"/> HTLV1/HTLVII
Comments	_____

Laboratory Use Only	
Specimen priority	<input type="checkbox"/>
Specimen volume	<input type="checkbox"/>
TF	<input type="checkbox"/>