OFFICE OF LABORATORY SERVICES
167 11th Avenue
South Charleston, WV 25303
PH: (304) 558-3530
FX: (304) 558-2006 or 6210

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	ETHNICITY
❑ White ❑ Asian ❑ Black ❑ Other ❑ American Indian/Alaskan ❑ Native Hawaiian or other Pacific Islander	❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑Unknown

PATIENT TYPE(for Hepatitis Testing only)
❑ Employee ❑ Medically Indigent ❑ Patient ❑ Investigation

CLINIC #

SUBMITTER INFORMATION

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)

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

USE ONE FORM PER SPECIMEN

DATE OF COLLECTION:

Program Type (Select ONE Only):

❑ APC(For anonymous HIV testing only)	❑ HIV Clinic
❑ College / University -FP	❑ Jail / Prison
❑ College / University -STD	❑ Juvenile Detention Center
❑ Family Planning	❑ **Project #** _____
❑ Fee for Service	❑ STD Clinic/STD Services
❑ Hospital	❑ TB Clinic

TEST REQUESTED (Select ONE Only):

❑ Hepatitis A IgM (Approval required from Program)	❑ Rubella Screen
	❑ Syphilis Screen (RPR)
❑ Hepatitis B Screen	❑ CT/GC Amplified (urine) / NAAT
❑ Hepatitis C Antibody	❑ HIV
❑ Hepatitis Post-Vac (HBsAb) **FEE FOR SERVICE**	❑ 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
❑ IUD Insertion	

HEPATITIS INFORMATION -RISK FACTORS (R. F.)

For Hepatitis B testing - patient must have at least one of the **bolded** risk factors to be eligible for Hepatitis B testing. Then mark all risk factors for hepatitis B. All R.F. should have occurred within the **past 12 months.**
For Hepatitis C testing- mark if patient **EVER** had a history of any of the listed risk factors. **One form for Hepatitis B and One form for Hepatitis C**

❑ **BODY PIERCING (NON -COMMERCIAL)**	❑ **MULTIPLE PARTNERS**
❑ **IV DRUG USER**	❑ **TATTOO (NON-COMMERCIAL)**
❑ Blood transfusions	❑ Illicit non-IV drug use
❑ Healthcare worker	❑ Needle stick/blood splash
❑ Hemodialysis	❑ Pregnant (due date _____)
❑ History of incarceration	❑ Sexual contact
❑ Household contact	❑ Symptoms / Diagnosis of STD

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 _____)	

PLACE HIV TEST FORM BARCODE LABEL HERE