



RIDH DATE RECEIVED

RHODE ISLAND HEALTH LABORATORIES
50 ORMS ST. PROVIDENCE, RI 02904-9971
401-222-5600, FAX 401 222-6985, TTY 1-800-745-5555
Web Site: www.health.state.ri.us

CLIENT NUMBER



3291243

INSTRUCTIONS

Print capital letters & numbers completely inside boxes: Print firmly & neatly with blue or black pen.

Please complete all items on form.

HIV SEROLOGY TEST

PATIENT INFORMATION

Important: Instructions for collection of Blood Specimens for HIV Antibody Test

- 1) Collect aseptically 5 ml of WHOLE CLOTTED BLOOD in a 16 X 100 mm red-top vacutainer tube. Do not use anticoagulant or preservative. Separated serum is acceptable (2-4 ml) but whole blood is preferred.
- 2) Hemolyzed Blood is unsatisfactory. Do not freeze whole blood.
- 3) Samples must be mailed to lab in proper biohazard containers. (Contact Preparation Room for information 222-5548).
- 4) HIV Test results will not be given through telephone correspondence. No exceptions.
- 5) The demographic information requested on this form is necessary for gathering epidemiologic data to help in the control of this disease. A specimen will not be processed until this information is provided.

Sex (M/F) Date of Birth (MMDDYYYY) Residence Zip Code - Specimen Collection Date

Print Full Name of Ordering Medical Provider (as appears on State License) _____ State Medical License # -

To Whose Attention Should this Report Be Sent? (full name): _____ ID #:

Duplicate Report Requested? Yes--Send to (full name): _____ State Medical License # -

- | | | | |
|--|--|---|---|
| <p>Ethnicity</p> <p><input type="checkbox"/> 1. Unknown</p> <p><input type="checkbox"/> 2. Hispanic/Latino</p> <p><input type="checkbox"/> 3. Portuguese</p> <p><input type="checkbox"/> 4. None of above</p> | <p>Race (Mark all that apply)</p> <p><input type="checkbox"/> A. Unknown/Refused</p> <p><input type="checkbox"/> B. White</p> <p><input type="checkbox"/> C. Black or African-American.</p> <p><input type="checkbox"/> D. American Indian (including So. And Central America)</p> <p><input type="checkbox"/> E. Native Hawaiian/Pacific Islander</p> <p><input type="checkbox"/> F. Laotian</p> <p><input type="checkbox"/> G. Cambodian</p> <p><input type="checkbox"/> H. Hmong</p> <p><input type="checkbox"/> I. Other Asian</p> <p><input type="checkbox"/> J. Other</p> | <p>Risk Factor</p> <p><input type="checkbox"/> 1. I.V.D.U.</p> <p><input type="checkbox"/> 2. Homosexual/Bisexual</p> <p><input type="checkbox"/> 3. Homosexual/Bisexual/I.V.D.U.</p> <p><input type="checkbox"/> 4. Hemophiliac</p> <p><input type="checkbox"/> 5. Blood Product Recipient</p> <p><input type="checkbox"/> 6. Heterosexual</p> <p><input type="checkbox"/> 7. Pediatric</p> <p><input type="checkbox"/> 8. Occupational/Healthcare Worker</p> | <p>Reason for Test</p> <p><input type="checkbox"/> A. Re-test</p> <p><input type="checkbox"/> B. Pre-Marital</p> <p><input type="checkbox"/> C. Pre-Natal</p> <p><input type="checkbox"/> D. Requested by patient</p> <p><input type="checkbox"/> E. Requested by physician</p> <p><input type="checkbox"/> F. Court ordered ACI</p> <p><input type="checkbox"/> G. Special study</p> <p><input type="checkbox"/> H. Work place exposure</p> |
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1. Remove 1st. label and firmly attach to blood tube **lengthwise**.
2. Remove 2nd label. Provide to patient to obtain results from their physician.
3. Remove 3rd label and use for patient's record.

DO NOT remove or detach other labels from form. They are for lab use.

ADHERE TO SPECIMEN CONTAINER(S)

| | | |
|-------------------|----------------------------|----------------------------|
| FOR RIDH USE ONLY | <input type="checkbox"/> R | <input type="checkbox"/> S |
| | Red | Serum |

WHITE: STATE LAB COPY

Ver. 2001- 1b

PINK: SUBMITTER COPY