

Specimen Type: Check appropriate specimen and fill in requested information (Only one sample per form).

- Oral mucosal transudate
- Serum
- Plasma
- Cadaver serum

PATIENT: _____ last first

BIRTH DATE: ____ / ____ / ____ mm dd year SSN #: ____ - ____

ADDRESS: _____

CITY: _____ STATE: ____ ZIP: ____

PHONE: (____) ____ - _____ GENDER: Female Male

RACE: White Black Asian American Indian / Alaskan Native
 Native Hawaiian / Pacific Islander Unknown

ETHNICITY: Hispanic Non Hispanic Unknown

DATE COLLECTED: ____ / ____ / ____ mm dd year

PATIENT ID #: _____

CLINICIAN: _____ CLINICIAN ID #: _____
please print last first

PHONE: (____) ____ - _____ CLINICIAN'S Signature: _____

Test(s) Requested

- HIV Antibody Screen
 - Western Blot Confirmation
- Previous Reactive Test Method _____ (required for confirmation)

Human Immunodeficiency Virus (HIV)
Test Request Form

MEDICAID / MEDICARE INFORMATION

Patient's Medicaid/Medicare #: _____

Physician Provider #: _____

Patient's Medicaid/Medicare ICD9 Code: _____

Referring Physician # (Medipass only): _____

If insurance is primary to Medicaid / Medicare

Insured's Name: _____
please print

Insured's ID#: _____

Insurance Company Name: _____

Insurance Company Address: _____

City: _____ State: ____ Zip: _____

Place IDPH Label Here

Facility Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Enter your facility address
Results are returned
to this address

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