OFFICE OF LABORATORY SERVICES
Andrea M. Labik, Sc.D. / Director
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 ❑ White ❑ Asian ❑ Black ❑ Other ❑ American Indian/Alaskan ❑ Native Hawaiian or other Pacific Islander	ETHNICITY ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑Unknown	

CLINIC #

SUBMITTER INFORMATION

FACILITY NAME Hancock County Health Department		
MAILING ADDRESS PO Box 578		
CITY New Cumberland	STATE WV	ZIP 26047
COUNTY Hancock County		
ATTENTION TO:		
PHONE NO. (include area code) 1-304-564-3343		
FAX NO. (include area code) 1-304-564-3410		

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):	
	❑
	❑
	❑
	X Project # D14-40
	❑
	❑

TEST REQUESTED (Select ONE Only):	
❑	❑
	❑
❑	❑
❑	X HIV
❑	❑

SOURCE OF SPECIMEN:	
X Blood / Serum	

HIV INFORMATION (Select all that apply)	
RISK FACTORS	HETEROSEXUAL RELATIONS WITH
X Pain Clinic Patient	❑ IV injection drug user
❑ Sex with male	❑ Bisexual male
❑ Sex with female	❑ Person with hemophilia/clotting disorder
❑ Injected non-Rx drugs	❑ Transfusion recipient WITH documented HIV positive
❑ Rec'd Clotting Factor F VIII A	❑ Transplant WITH documented HIV positive
❑ Rec'd Clotting Factor F IX B	❑ Person with AIDS or documented HIV positive
❑ Blood transfusion	❑ Unspecified risk
❑ Rec'd transplant or artificial insemination	
❑ Healthcare worker / lab worker	*PLACE HIV TEST FORM BARCODE LABEL HERE*
❑ Pregnant (due date _____)	