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

CLINIC #

SUBMITTER INFORMATION

FACILITY NAME
Marshall County Health Department

MAILING ADDRESS
PO Box 429

CITY	STATE	ZIP
Moundsville	WV	26041

COUNTY
Marshall County

ATTENTION TO:

PHONE NO. (include area code)
1-304-845-7840

FAX NO. (include area code)
1-304-843-9837

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 _____)	