WEST VIRGINIA Department of Health & Human Resources BUREAU FOR PUBLIC HEALTH

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

OLS USE ONLY
[place barcode label HERE]

DIAGNOSTIC IMMUNOLOGY LABORATORY SPECIMEN SUBMISSION FORM

USE ONE FORM PER SPECIMEN

PATIENT INFORMATION

PATIENT ID (Chart #, etc.) *(optional)*		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# (last 4 digits only)	
COUNTY OF RESIDENCE	SEX (at birth) ❑ 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	

DATE OF COLLECTION:

PROGRAM/CLINIC 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	❑ STD Clinic / STD Services
❑ Hospital	❑ Project HRP
❑ Project # ______________________________	

TEST REQUESTED: (Select ONE Only)	
❑ CT/NG Amplified NAAT	❑ Rubella Screen
	❑ Syphilis Screen (RPR)
❑ HIV Confirmation Test (*for Rapid HIV Program ONLY*)	❑ HIV

SOURCE OF SPECIMEN:	
❑ Blood / Serum	❑ Urine

Is patient pregnant? ❑ NO ❑ YES (due date ____________________)

CT/NG INFORMATION – REASON FOR TEST (as per guidelines)	
❑ Any symptom of STD	❑ Re-screen of previous positive (*minimum of three [3] months after treatment*)
❑ Known contact to STD	❑ Suspect / Possible contact to STD (*new partner, multiple partners, polygamous partner*)
❑ IUD Insertion	

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 and/or Lab worker	*PLACE HIV TEST FORM BARCODE LABEL HERE*

SUBMITTER INFORMATION

FACILITY NAME		
MAILING ADDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO:		
PHONE NO. (include area code)		
FAX NO. (include area code)		

COMMENTS:

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

Failure to fill out this form correctly may result in rejection of specimen for testing.