S3

UKHSA Microbiology request form

HIV Reference Test

UK Health Security Agency

Virus Reference Department
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London NW9 5HT

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vrdqueries@ukhsa.gov.uk
www.gov.uk/ukhsa

UKHSA Colindale
(VRD)
DX 6530006
Colindale NW

Please write clearly in dark ink

SENDER'S INFORMATION

Report to be sent FAO

Contact Phone Ext

Purchase order number

Project code

Postcode

PATIENT/SOURCE INFORMATION

☐ Inpatient ☐ Outpatient ☐ GP Patient ☐ Other* *Please specify

NHS number

Sex ☐ male ☐ female ☐ unknown

Surname

Date of birth Age

Forename

Patient's postcode

Pregnant ☐ Yes ☐ No **Breast feeding** ☐ Yes ☐ No

Hospital number

Ward/ clinic name

Hospital name *(if different from sender's name)*

Ward type

Ethnic information

w ☐ White m ☐ Black Caribbean n ☐ Black African p ☐ Black other y ☐ Indian/Pakistani/Bangladeshi x ☐ Other/Mixed

Have previous samples been sent to UKHSA ☐ Yes ☐ No

UKHSA reference number

SAMPLE INFORMATION

Your reference

Sample type ☐ Serum/plasma ☐ EDTA whole blood

Date of collection Time

Date sent to UKHSA

Please tick the box if your clinical sample is post mortem ☐

Do you suspect from clinical or lab information that patient is infected with Hazard Group 3 or 4 pathogen (in addition to the requested investigation)?

If yes, give all relevant details

Note: if infection with a Hazard Group 4 pathogen is suspected, from clinical information or travel history, you must contact the lab before sending

MOTHER TO CHILD TRANSMISSION (MTCT) INVESTIGATION

Important: For MTCT investigations, please provide the following information for the corresponding mother/child

Name

Date of birth

If previously tested at UKHSA please provide reference number

TESTS REQUESTED

☐ HIV confirmation ☐ HIV-1 proviral DNA detection ☐ Maternal transmission (mother HIV positive)

☐ HIV-1 recency/avidity test ☐ HIV-1 RNA detection ☐ Maternal transmission (mother's HIV status unknown)

SENDER'S LABORATORY RESULTS

	ASSAY/KIT	Product no.	OD 1	OD 2	Cut off	Result/Interpretation
1						
2						
3						

Current HIV test results *(where available)*

1 ☐ HIV-1 positive 3 ☐ HIV-2 positive

2 ☐ Untyped 4 ☐ Indeterminate

Has the patient ever received an HIV test prior to this diagnosis?

☐ No ☐ Yes *(please specify date(s) below)*

Date **last negative** *(if any)*

Date **earliest positive** in the UK

CLINICAL INFORMATION

HIV Seroconversion	☐ Yes	☐ No	☐ Unknown
Has the patient received HIV PrEP in the last 6 months?	☐ Yes	☐ No	☐ Unknown
Has the patient received another form of ARV in the last 6 months?	☐ Yes	☐ No	☐ Unknown