

HIV-1 Viral Resistance & Tropism by Genotype Test Request Form

PATIENT DETAILS

Affix patient label here

Complete ONLY if no label available

*Hospital/Clinic No.

*Sample ID

Patient ID

*Date of Birth

Please note that fields marked with * are compulsory. At least 3 unique patient identifiers must be included.

Sex M F

*TEST(S) REQUESTED (tick as appropriate)	Tick if required	Sample	Volume
HIV-1 Viral Resistance Testing Virco®TYPE HIV-1 (Genotype + Interpretation)	<input type="checkbox"/>	Plasma	2ml
HIV-1 Tropism by Genotype – RNA Plasma <i>Samples with HIV VL >500 copies/ml</i>	<input type="checkbox"/>	Plasma	2ml
HIV-1 Tropism by Genotype – Proviral DNA <i>Samples with HIV VL <500 copies/ml</i>	<input type="checkbox"/>	Whole Blood	1ml

Optional: Please note that for the HIV-1 Tropism by Genotype, inclusion of the patient’s Viral Load, **lowest ever** CD4 and CD8 T cell absolute values (counts) and the CD4 T cell percentage can all help improve the prediction of viral tropism.

CD4 cells/mm³ (Lowest ever absolute value) Viral Load copies/ml -taken at time of sample

CD4 % (Lowest ever percentage)

CD8 cells/mm³ (Lowest ever absolute value)

DATE OF SAMPLE

*Sample collection date (e.g. 01 JAN 2011)
Day Month Year

CLINICAL CENTRE INFORMATION

*Customer number

*Address

*Postcode

Tel

Fax

*Email

*Contact

REQUESTING HEALTH PROFESSIONAL

*Name (BLOCK CAPITALS)

Date
Day Month Year

COMMENTS

FOR LAB21 USE ONLY

ID No: _____ **Date:** _____ **Entered by:** _____ **Validated by:** _____