Human Immunodeficiency Virus (HIV) Test Request Form

Specimen Type: Check appropriate specimen and fill in requested information (Only one sample per form).

- ☐ Oral mucosal transudate
- ☐ Serum
- ☐ Plasma

DATE COLLECTED: ____ / ____ / ____ (mm / dd / year)

PATIENT: _____ (last) _____ (first)

BIRTH DATE: ____ / ____ / ____ (mm / dd / year) SSN #: ___ – ___

ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____

PHONE: ( ) - GENDER: ☐ Female ☐ Male

RACE: ☐ White ☐ Black ☐ Asian ☐ American Indian / Alaskan Native ☐ Native Hawaiian / Pacific Islander ☐ Unknown

ETHNICITY: ☐ Hispanic ☐ Non Hispanic ☐ Unknown

PATIENT ID #: _____

CLINICIAN: _____ (please print last first) CLINICIAN ID #: _____

PHONE: ( ) - CLINICIAN'S Signature:

☐ As the clinician providing care to this patient, I request that this test be performed without charge to this patient because of the imminent and significant public health threat posed by the differential diagnosis.

Test(s) Requested

- ☐ HIV Antigen/Antibody Screen
- ☐ HIV Confirmation Testing

Previous Reactive Test Method _____ (required for confirmation)

State Hygienic Laboratory
University of Iowa Research Park
2490 Crosspark Road, Coralville, IA 52241
Phone #: 319-335-4500
Fax #: 319-335-4555
http://www.shl.uiowa.edu

MEDICAID / MEDICARE INFORMATION

Patient's Medicaid/Medicare #: _____

Physician Provider #: _____

ICD9 Diagnosis Code (REQUIRED): _____

Referring Physician # (Medipass only): _____

If insurance is primary to Medicaid / Medicare

Insured's Name: _____ (please print)

Insured's ID#: _____

Insurance Company Name: _____

Insurance Company Address: _____

City: _____ State: ___ Zip: _____

Place IDPH Label Here

Facility Name: _____

Address: _____

City: _____ State: ___ Zip: _____

Enter your facility address
Results are returned
to this address