



HIV-1

TEST REQUEST FORM

Oregon State Public Health Laboratory
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Portland, OR. 97201
PH: (503) 229-5882 FAX (503) 229-5682

OSPHL USE ONLY



03-803671

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Care Service/ Clinic Code: [] CTS HIV [] Family Planning [] Primary Care [] Drug Treatment [] Field Visit [] STD [] Corrections/Jail [] Prenatal [] Tuberculosis [] Other Epi Code: [][][][] For county use: _____

CTRS PROVIDER - RETURN ADDRESS FOR REPORT

Phone: _____ [][][][][][] Submitter Code

[] LHD/Subcontractor [] Other Forward to: _____

TEST INFORMATION

Test Choice: [] Anonymous [] Confidential Date collected _____ Specimen Type: [] Serum [] Oral fluid [] Other _____

[] Rapid Test: Result: [] NEGATIVE [] PRELIMINARY POSITIVE

Note: Send this form in to the lab with another serum or Orasure specimen if the result is "preliminary positive".

CLIENT INFORMATION (Answer every question):

County of Residence: _____ State: _____ Zip Code: _____ DOB: _____ Sex: [] Male [] Female [] Other

TEST HISTORY

History of previous HIV testing (check one only) [] YES [] NO If yes, last test result was [pos] [neg] [ind] [unk] Date of last test: _____ Previous OR HIV ID#, if known: _____

ETHNICITY (Check one):

[] Hispanic or Latino [] Not Hispanic or Latino

RACE (Select one or more):

[] Am Indian/AK Native [] Asian [] Black/African-American [] Native Hawaiian/ Pacific Islander [] White

CLIENT'S REASON FOR TEST (Check one only):

- [] Part of prenatal care
[] Self-initiated and asymptomatic
[] Client reports symptoms suggestive of HIV infection
[] Referred from STD clinic
[] DIS or epi nurse referral/ Notified of HIV contact
[] Court-ordered
[] Immigration/Travel requirement
[] Occupational exposure
[] Victim of sexual assault
[] Other _____

RISK HISTORY (Check all that apply): REFERRALS MADE TO:

- [] INJECTION DRUG USE [] primary care/physician [] STD clinic [] HIV prevention program [] mental health [] substance abuse treatment [] needle exchange [] social services
[] SEX FOR DRUGS, MONEY, OR SURVIVAL
[] OTHER RISK: _____ [] OTHER: _____
[] NO IDENTIFIED RISK [] NO REFERRALS MADE

This individual for whom a human immunodeficiency virus (HIV) test has been requested, has been informed about the HIV test in full accordance with Oregon laws and regulations and has consented to be tested. The individual has been given the full opportunity to ask questions and receive adequate answers.

Health Care Provider's Name (please print) Health Care Provider's Signature Date

SEND THIS FORM TO THE OREGON STATE PUBLIC LABORATORY WITH SPECIMEN OHD 44 (REV 1/03)

Notes: _____

Client's name: _____ Date Post-Test Counseling Scheduled: _____ Address: _____ Medicaid ID Number: _____ City: _____ State: _____ Zip: _____ Phone: _____

SUBMITTER COPY—REMOVE AND RETAIN AT TESTING SITE BEFORE SUBMITTING SPECIMEN