



## BLOOD BORNE VIRUS INVESTIGATION REQUEST FORM

### PATIENT DETAILS

Forename:

DOB:

Surname:

Sex:  F  M

Address:

### SPECIMEN DETAILS

Specimen Type(s):  Serum  Plasma  Other:

Specimen Date & Time of collection:

### CLINICAL DETAILS

Clinical details aid the selection of an optimal testing strategy.

Date of onset of symptoms:

**Most likely route of infection:**

Men who have sex with men .....

Injecting drug use .....

Hetrosexual .....

Mother - to - child .....

Occupational exposure .....  Type \_\_\_\_\_

When did exposure occur \_\_\_\_\_ Date \_\_\_\_\_

Other \_\_\_\_\_

Clinical Details \_\_\_\_\_

Asymptomatic  Symptomatic

Details \_\_\_\_\_

HBV vaccination details \_\_\_\_\_

Full course  Booster

Number of months after final dose (please specify): \_\_\_\_\_

Other relevant information including details of treatment where appropriate: \_\_\_\_\_

### INVESTIGATION REQUIRED (For sample collection requirements please refer to the NVRL User Manual ([nvrl.ucd.ie](http://nvrl.ucd.ie)))

**Blood Borne Virus Serology**

HIV .....

HBsAg .....

anti-Hbcore .....

anti-HBs .....

Hepatitis C .....

Other (please specify) \_\_\_\_\_

**Investigations required Blood Borne Virus Molecular**

HIV 1 RNA .....

Hepatitis C RNA .....

Hepatitis C Genotype ....

Hepatitis B DNA .....

Other (please specify) \_\_\_\_\_

### DOCTOR / SURGERY DETAILS/REQUESTING HOSPITAL DETAILS

Name:

Signature:

IMC No:

Date:

Tel:

**Surgery Address / Hospital Address/Stamp**

N.B. Please note that the sample will not be processed without address of surgery or hospital