National Virus Reference Laboratory
University College Dublin
Belfield, Dublin 4

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HIV TROPISM DETERMINATION REQUEST FORM

PATIENT DETAILS

Forename: | | | | | | | | | | | | |

DOB: D D | M M | Y Y Y Y

Surname: | | | | | | | | | | | | |

Sex : F | M

Address:

SPECIMEN DETAILS

Specimen Type(s): EDTA WHOLE BLOOD | Plasma

Specimen Date & Time of collection: D D | M M | Y Y Y Y — H H | M M

Specimen type depends on the current / recent HIV plasma viral load :

–HIV Viral Load >1000 copies/ml : At least 2ml of frozen plasma

–HIV Viral Load <1000 copies/ml : 10ml unprocessed EDTA blood †

†EDTA samples must arrive to the NVRL no later than 3pm to allow for processing

Sample Type

☐ 2ml Plasma

☐ 10ml EDTA Whole Blood

Date sent to NVRL : D D | M M | Y Y

REQUIRED CLINICAL DETAILS

Reason for test

Starting HAART .... ☐

HAART Failure .... ☐

Switching HAART for reason other than failure (e.g. toxicity) ... ☐

Other (please specify): ____________________

Treatment History :

☐ **Naïve**

☐ **Experienced**

Current Therapy Status :
(at time of sample collection)

☐ **On therapy**

☐ **Off therapy**

Most recent viral load at time of sample ____________________ copies/ml

Nadir (lowest recorded) CD4

– Absolute No. __ cells/mm^3

– Percentage __ %

* Please ensure that the above information is provided as completely as possible – the bioinformatic algorithm used to determine HIV tropism requires the data requested to produce a reliable result.

REQUESTING HOSPITAL DETAILS

Name:

Signature:

IMC No: | | | | | |

Date: D D | M M | Y Y Y Y

Tel:

Hospital Address/Stamp

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

This is a controlled document.
Printed copies are valid until date of next review