



National Virus Reference Laboratory
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BLOOD BORNE VIRUS INVESTIGATION REQUEST FORM

PATIENT DETAILS

Forename:

DOB:

D	D	M	M	Y	Y	Y	Y
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Surname:

Sex: F M

Address:

Hospital Number (Mandatory if available):

Hospital Lab Number (Mandatory if available):

SPECIMEN DETAILS

Specimen Type(s):

Serum	Plasma
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 Other:

Specimen Date & Time of collection:

D	D	M	M	Y	Y	Y	Y
H	H	M	M				

Collection Details

Sample collected by:

Signature:

CLINICAL DETAILS

Clinical details aid the selection of an optimal testing strategy.

Date of onset of symptoms:

D	D	M	M	Y	Y	Y	Y
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Most likely route of infection:

Men who have sex with men

Injecting drug use

Heterosexual

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))

Blood Borne Virus Serology

HIV

HBsAg

anti-HBcore

anti-HBs

Hepatitis C

Other (please specify) _____

Investigations required Blood Borne Virus Molecular: PLASMA required

HIV 1 RNA

Hepatitis C RNA

Hepatitis C Genotype

Hepatitis B DNA

Other (please specify) _____

Other Investigations

HIV Tropism

HIV Resistance

DOCTOR / SURGERY DETAILS/REQUESTING HOSPITAL DETAILS

Name:

Signature:

IMC No:

Date:

D	D	M	M	Y	Y	Y	Y
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Tel:

Surgery Address / Hospital Address/Stamp

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