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BLOOD BORNE VIRUS INVESTIGATION REQUEST FORM

PATIENT DETAILS

Forename:

DOB: D D M M Y Y Y Y

Surname:

Sex : F M

Hospital Number

Address:

Hospital Lab Number

SPECIMEN DETAILS

Specimen Type(s): Serum Plasma

Other:

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

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

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))

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: D D M M Y Y Y Y

Tel:

Surgery Address / Hospital Address/Stamp

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