**NVRL HIV GENOTYPIC RESISTANCE ASSAY REQUEST FORM**

**PATIENT DETAILS**
- Forename: 
- Surname: 
- Address: 
- DOB: 
- Sex: F M

**SPECIMEN DETAILS**
- Specimen Type(s): Serum Plasma Other: 
- Specimen Date & Time of collection: 
- Hospital Laboratory Number: 

Please send at least 5ml EDTA whole blood or 2ml plasma. 
Has this sample been stored? □ Yes □ No
Has consent been obtained for residual sample to be used in other assay? □ Yes □ No

**CLINICAL DETAILS**
- Reason for test:
  - New Diagnosis
  - Treatment Failure
  - Poor response to treatment
  - First time commencing ART
  - Re-starting ART after interruption
  - Acute primary infection / seroconversion
  - Pregnancy
  - Other (please specify ____________)

Adherence:
- □ Excellent
- □ Fair
- □ Poor
- □ No opinion

Most recent viral load at time of sample: copies
Date of most recent viral load:
CD4 count: Date:

Was patient on therapy when sample was taken? □ Yes □ No
If not, has the patient ever been on therapy? □ Yes □ No

**INVESTIGATION REQUIRED:**
- □ RT & Protease
- □ Integrate (for RAL)

**REQUESTING HOSPITAL DETAILS**
- Name: 
- Signature: 
- IMC No: 
- Date: 
- Tel: 

**Hospital Address/Stamp**
N.B. Please note that the sample will not be processed without address of surgery or hospital.

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