National Virus Reference Laboratory
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Belfield, Dublin 4

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NVRL HIV GENOTYPIC RESISTANCE ASSAY 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

D D M M

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 ☐ **Integrase (for RAL)** ☐

CLINICAL DETAILS

* Details of Current/ Previous Therapies

NTRIs	Current/ most recent	Previous	**PIs**	Current/ most recent	Previous
ZDV	☐	☐	ATV	☐	☐
D4T	☐	☐	IDV	☐	☐
ddI	☐	☐	NFV	☐	☐
3TC	☐	☐	LPV/r	☐	☐
FTC	☐	☐	RTV(any dose)	☐	☐
ABC	☐	☐	SQV	☐	☐
TDF	☐	☐	DRV	☐	☐
			TPV	☐	☐
NNTRIs			**EIs**		
NVP	☐	☐	T-20	☐	☐
EFV	☐	☐	MRV	☐	☐
ETV	☐	☐			
RPV	☐	☐			
Integrase Inhinitors	☐				
RAL	☐				
EVG					

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