

Cadham Provincial Laboratory
HIV Nucleic Acid
Testing Requisition



All areas of the requisition must be completed (please **print** clearly)

Cadham Provincial Laboratory
P.O. Box 8450
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Tel: (204) 945-6123
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Website: www.gov.mb.ca/health/publichealth/cpl/

ADDRESSOGRAPH

TYPE OF TEST REQUESTED		PATIENT INFORMATION	
<input type="checkbox"/> Plasma Viral Load ¹ <input type="checkbox"/> Genotyping/Drug Resistance ¹ <input type="checkbox"/> Provirus (call lab to arrange) ² <input type="checkbox"/> gp41 ¹ <input type="checkbox"/> Proviral DNA Tropism (call lab) ² <input type="checkbox"/> Co-receptor Tropism (call lab) ¹		PHIN: _____ MB Health Reg. # _____	
Most recent CD4 Count: Cells/ μ l: _____ Date: _____		Alternate ID: _____ <input type="checkbox"/> RCMP # <input type="checkbox"/> Other Provinces/Territories <input type="checkbox"/> Military # <input type="checkbox"/> Other _____	
REASON FOR VIRAL LOAD TESTING		Date of Birth: _____ Sex: _____ Chart/Clinic/Lab # _____ YYYY/MM/DD M F U A	
<input type="checkbox"/> 1. Initial Assessment <input type="checkbox"/> 2. Three month follow-up <input type="checkbox"/> 3. Monitoring Therapy (four weeks after start of medication) <input type="checkbox"/> 4. Change of Therapy (four weeks following change of medication) <input type="checkbox"/> 5. Antepartum Pregnant (only performed on serologically-confirmed cases) <input type="checkbox"/> 6. Infant postnatal follow-up <input type="checkbox"/> 7. Previously suppressed VL now Detectable (patient adhering to therapy) <input type="checkbox"/> 8. Other: _____		<input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Uninsured	
CURRENT ANTIRETROVIRALS		PATIENT LEGAL NAME	
NRTI <input type="checkbox"/> 3TC Lamivudine <input type="checkbox"/> ABC Abacavir <input type="checkbox"/> AZT Zidovudine <input type="checkbox"/> D4T Stavudine <input type="checkbox"/> ddI Didanosine <input type="checkbox"/> FTC Emtricitabine <input type="checkbox"/> TDF Tenofovir NNRTI <input type="checkbox"/> EFV Efavirenz <input type="checkbox"/> ETV Etravirine <input type="checkbox"/> NVP Nevirapine Others: 		(Last) _____ (First) _____	
PI <input type="checkbox"/> ATV/r Atazanavir <input type="checkbox"/> DRV/r Darunavir <input type="checkbox"/> FPV/r Fosamprenavir <input type="checkbox"/> IDV/r Indinavir <input type="checkbox"/> LPV/r Lopinavir <input type="checkbox"/> NFV Nelfinavir <input type="checkbox"/> SQV/r Saquinavir <input type="checkbox"/> TPV/r Tipranavir Integrase Inhibitors <input type="checkbox"/> RAL Raltegravir <input type="checkbox"/> EVG Elvitegravir		PATIENT PRIMARY RESIDENTIAL/CIVIC ADDRESS	
		Street or Other (e.g., General Delivery) _____ Phone # _____	
		City/Town/Village/Rural Municipality/First Nations Reserve _____ Postal Code _____	
		ORDERING PRACTITIONER INFORMATION	
		(Last Name) _____ (First) _____	
		REPORT RETURN ADDRESS	
		Street Address _____	
		Facility Name _____	
		Ward/Clinic Name _____ City/Town _____	
		Postal Code _____ Phone # _____ Secure Fax # _____	
		COPY REPORT TO	
		(Practitioner Last Name) _____ (First Name) _____	
		Address _____ City/Town _____	
		Postal Code _____ Phone # _____ Secure Fax # _____	
		<p align="center">IMPORTANT</p> <ul style="list-style-type: none"> • Specimens must be labelled with two unique identifiers. <ul style="list-style-type: none"> • Label specimen with patient's full name and PHIN (or alternate ID). • Improperly labelled specimens will not be tested. • Specimen Collection Date and Time and Specimen Type fields on the requisition must be filled in. <p>1. Collect 10 mL EDTA WHOLE blood (Lavender top tube) and send to CPL within 4 hours, OR Refrigerate centrifuged EDTA plasma and send to CPL on cold pack within 72 hours, OR Send FROZEN centrifuged EDTA plasma on dry ice or within a block of ice if dry ice is not available. Pediatric sample volume – 5 ml EDTA WHOLE blood delivered to CPL within 4 hours</p> <p>2. Provirus and Proviral DNA Tropism require EDTA WHOLE blood at room temperature (do not centrifuge) within 4 hours. Call 945-7545 for consult. Call 945-7612 to arrange sample submission.</p>	
SPECIMEN INFORMATION			
Collected By (Phlebotomist): _____ Facility: _____			
Date: _____ Time: _____ YYYY/MM/DD			
Specimen Type: _____			