CAMBRIDGE CLINICAL LABORATORIES

HIV-1 Virology Services Test Request Form

PATIENT DETAILS

Please note that fields marked with * are compulsory.

Affix patient label here

* ID 1	
* ID 2	
ID 3	
*Date of Birth	
Gender	☐ Male ☐ Female

At least 3 unique patient identifiers must be included on samples and request form.

*TEST(S) REQUESTED

EDTA PLASMA

Test	Sample	
HIV-1 PR-RT Resistance	>2ml Plasma	☐
HIV-1 Integrase Resistance	>2ml Plasma	☐
Viral RNA HIV-1 V3 Tropism by Genotype *Recommended for samples with HIV VL >500 copies/ml*	>2ml Plasma	☐
*Sample collection date (e.g DD MMM YYYY)		

EDTA WHOLE BLOOD

Test	Sample	
HLA-B*57:01 genotyping	>2ml EDTA Whole Blood	☐
*Sample collection date (e.g. DD MMM YYYY)		

Previous HIV-1 Viral Load ______ copies/ml Date of result: ______

CLINICAL CENTRE INFORMATION

If you do not know your customer DD Code please contact CCL for assistance.

*CCL Account Number	DD
*Address	
*Postcode	
Tel	
Fax	
*Email	
*Contact	

REQUESTING HEALTH PROFESSIONAL

*Name (BLOCK CAPITALS)	
Date	
Comments	

FINANCE DETAILS

Please provide any finance authorisation details we may require when invoicing.

PO Number	
Cost Centre	
Budget Holder	

CCL USE ONLY CCL ID No .... Date.. Entered by...................................... Validated by.......................................

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