

DIAGNOSTIC HIV PEDIATRIC LABORATORY  
 WADSWORTH CENTER  
 NEW YORK STATE DEPARTMENT OF HEALTH  
 ALBANY, NY 12201-2002

For lab use only	LAB ACCESSION #	RECORD I.D. NO.

**DIAGNOSTIC HIV PEDIATRIC LABORATORY REQUISITION**  
**TEST RESULTS MAY BE DELAYED IF THIS FORM IS NOT COMPLETE**

<b>Please indicate if this is as initial or follow-up test for this infant:</b>				
<input type="checkbox"/> INITIAL PCR TEST (PLEASE INDICATE TIME FRAME)		<input type="checkbox"/> 0-2 DAY PCR TEST		<input type="checkbox"/> 2 WEEK PCR TEST
<input type="checkbox"/> FOLLOW-UP PCR TEST		<input type="checkbox"/> 1 MONTH PCR TEST		<input type="checkbox"/> 8-10 WEEK PCR TEST
<input type="checkbox"/> > 4 MONTH PCR TEST				
PATIENT LAST NAME	PATIENT FIRST NAME	PATIENT A.K.A	PATIENT CODE	
HOSPITAL MEDICAL RECORD #	NEWBORN SCREENING LAB I.D.	DATE OF BIRTH	AGE	DATE COLLECTED
RACE/ETHNICITY <input type="checkbox"/> WHITE <input type="checkbox"/> HISPANIC <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> BLACK <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	GESTATION (WKS)	BIRTHWEIGHT (GMS)
NAME OF BIRTH FACILITY	STATE OF BIRTH	COUNTY OF BIRTH		
COUNTY OF RESIDENCE	ZIP CODE, RESIDENCE	CHILD IN FOSTER CARE <input type="checkbox"/> YES <input type="checkbox"/> NO		
WERE ANTIRETROVIRALS GIVEN TO THE MOTHER? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN IF YES, LIST DRUGS _____		IF ANTIRETROVIRALS WERE GIVEN TO THE MOTHER, WHEN WERE THEY GIVEN? (CHECK ONE): <input type="checkbox"/> DURING BOTH PREGNANCY AND DELIVERY <input type="checkbox"/> PREGNANCY ONLY <input type="checkbox"/> DELIVERY ONLY		
WERE ANTIRETROVIRALS GIVEN TO THE INFANT FOR PERINATAL TRANSMISSION PROPHYLAXIS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN IF YES, LIST DRUGS _____		WAS THE INFANT TRANSFUSED? <input type="checkbox"/> YES <input type="checkbox"/> NO		

**CERTIFICATION BY PERSON AUTHORIZED TO ORDER THE HIV TEST**

Signature of Authorized Person _____	License Number _____
Printed Name of Authorized Person _____	Phone Number _____

If this PCR test specimen is from an infant born in New York State (NYS) who is six months of age or less, the signature above certifies only that you are the person authorizing the test. Otherwise, the signature both authorizes the test and certifies that informed consent pursuant to the requirements of NYS Public Health Law Article 27-F has been given by the individual tested or a person authorized by law to consent for the health care of an individual without capacity to consent to an HIV-related test. For specimens testing positive for HIV DNA, the signature authorizes additional HIV testing to determine the best treatment. The signature also verifies that the child has had positive HIV antibody tests or that the mother is known to be infected with HIV. Positive test results are reported to the New York State Department of Health.

**Please print, affix label, or type the complete name and address to whom the test results are to be reported.**

NAME	PHONE NUMBER	FAX NUMBER
ATTENTION TO	FACILITY NAME	
STREET ADDRESS	BLDG./ROOM NUMBER	
CITY	STATE	ZIP CODE

**SUBMIT THE TOP COPY TO THE LAB. MAINTAIN THE BOTTOM COPY FOR YOUR RECORDS.**