

Requisition will be returned if incomplete

Pediatric HIV Testing Service Requisition Notice to Physician or Physician Designee

As part of the New York State (NYS) Comprehensive Newborn HIV Screening Program, effective February 1, 1997, informed consent to PCR testing is not required on infants born in NYS who are six months of age or less. In this case, signing the requisition certifies that you are the person authorizing the test. If this PCR specimen is from an individual over six months of age or not born in NYS, informed consent must be obtained. Section 2781 of the NYS Public Health Law, effective January 1, 1989, requires the physician or other person authorized to order an HIV-related test to certify the following by signing the requisition:

"The person tested or a person authorized by law to consent for the health care of a person without the capacity to consent to an HIV-related test has given informed written consent for the performance of such test, pursuant to the requirements of Public Health Law (PHL), Article 27-F."

The law requires that informed consent for an HIV-related test include an explanation of the test and the meaning of the results and benefits of diagnosis and intervention, information on possible discrimination problems, information on preventing exposure or transmission of HIV infection, information on the voluntary nature of the test and availability of anonymous testing and an explanation of the confidentiality protection under PHL, Article 27-F.

The NYS Public Health Law, Article 27-F, also states that in all cases where test results are communicated to a subject, post-test counseling is required.

Note: Informed consent is not required: 1) when the test is performed on tissues, organs, or fluids for donation, transplantation, transfusion or for research where identity is not known.; 2) for testing a deceased person to determine the cause of death or for epidemiological purposes; 3) for court ordered testing pursuant to the NYS Civil Practices Law and Rules Section 3121; 4) for mandated newborn testing; or 5) if otherwise authorized or required by State or Federal Law.

For lab use only	Lab Accession # _____	Record I.D. No. _____
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NEW YORK STATE DEPARTMENT OF HEALTH
 Diagnostic HIV Pediatric Laboratory
 Wadsworth Center
 Albany, NY 12201-2002

Diagnostic HIV Pediatric Laboratory Requisition

Test Results May be Delayed if this form is not complete

Please indicate if this is an initial or follow-up test for this infant:

- | | | |
|--|---|---|
| <input type="checkbox"/> Initial PCR Test (Please indicate time frame) | <input type="checkbox"/> 2 Week PCR Test | <input type="checkbox"/> 4 Week PCR Test |
| <input type="checkbox"/> Follow-up PCR Test | <input type="checkbox"/> 8-10 Week PCR Test | <input type="checkbox"/> 16 Week 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 White Hispanic Native American Black Asian Other

Sex Male Female

Gestation (weeks): _____ Birthweight (GMS) _____

Name of Birth Facility _____ State of Birth _____ County of Birth _____

County of Residence _____ Zip Code, Residence _____

Child in Foster Care Yes No

Were antiretrovirals given to the mother? Yes No Unknown

If yes, list drugs _____

If antiretrovirals were given to the mother, when were they given? (Check one)

- During both pregnancy and delivery Pregnancy only Delivery only

Were antiretrovirals given to the infant for perinatal transmission prophylaxis? Yes No Unknown

If yes, list drugs _____

Was the infant transfused? Yes 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 tests 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.