NEW YORK STATE DEPARTMENT OF HEALTH
Wadsworth Center
David Axelrod Institute
120 New Scotland Avenue
Albany, NY 12208

# Bloodborne Viruses Laboratory Clinical Testing Requisition

**NYS Accession Number:**

## 1. Test Requested

**HIV TESTING: Complete Sections: 2 or 3, 4, 5, 6, 9**

☐ HIV DIAGNOSTIC TESTING (If rapid test was performed, check below):

☐ HIV RAPID TEST CONFIRMATION (Indicate rapid test kit in section 6)

☐ HIV-1 QUALITATIVE RNA TESTING (Section 6 must be completed)

☐ HIV-2 VIRAL LOAD TESTING ☐ HIV-2 QUALITATIVE RNA TESTING

☐ HIV - DEFENDANT TESTING DATE OF ALLEGED ASSAULT _______ / _______/ _______ (MO DAY YR)

**HEPATITIS C VIRUS (HCV) TESTING: Complete Sections: 3, 4, 5, 7, 9 (HCV testing by special request only)**

☐ HCV ANTIBODY TESTING WITH REFLEX TO HCV RNA TESTING

☐ HCV RNA TESTING ONLY (Section 7 must be completed)

☐ HCV GENOTYPING

☐ HCV VIRAL LOAD

## 2. Anonymous HIV Testing (NYSDOH approved sites only)

| PATIENT CODE (DO NOT USE PATIENT IDENTIFIERS) | ZIP CODE | COUNTY |
|---|---|---|
| | | |

## 3. Patient Name and Address (Do not complete for anonymous HIV testing) **required information*

| * PATIENT'S LAST NAME | * PATIENT'S FIRST NAME | MI |
|---|---|---|
| | | |

| * PATIENT'S STREET ADDRESS (IF INCARCERATED, USE DOCS FACILITY ADDRESS) |
|---|
| |

| * CITY | * STATE | * ZIP CODE | * COUNTY |
|---|---|---|---|
| | | | |

## 4. Patient Demographics **required information*

| * GENDER | * DATE OF BIRTH | IS PATIENT AN IMMIGRANT? | PATIENT MEDICAL RECORD # or DIN # |
|---|---|---|---|
| ☐ MALE ☐ FEMALE | _______ / _______ /_______ (MO DAY YR) | ☐ NO ☐ YES<br>If YES, ______________ COUNTRY OF ORIGIN ______________ ENTRY YEAR | |

* RACE (Select one or more): ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐ WHITE

* ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC

## 5. Specimen Information **required information*

| SPECIMEN TYPE | * COLLECTION DATE | COLLECTION TIME | NYSDOH OUTBREAK # (IF APPLICABLE) |
|---|---|---|---|
| ☐ PLASMA ☐ WHOLE BLOOD<br>☐ SERUM ☐ DRIED BLOOD SPOT | _______ / _______ /_______ (MO DAY YR) | AM<br>PM | |

## 6. HIV Previous Test Data

IF THIS SPECIMEN IS BEING SUBMITTED FOR REFERRAL TESTING, LIST ALL OTHER HIV TEST(S) THAT WERE PERFORMED AT THIS VISIT. IF RAPID TEST WAS PERFORMED, SPECIFY NAME OF RAPID TEST KIT(S) USED: ______________________________

HAS THIS PATIENT PARTICIPATED IN ANY HIV VACCINE TRIALS? ☐ NO ☐ YES IS PATIENT CURRENTLY TAKING ANTIRETROVIRALS? ☐ NO ☐ YES

## 7. HCV Previous Test Data

IS THIS A REQUEST FOR CONFIRMATION OF A REACTIVE HCV ANTIBODY SCREENING TEST? ☐ NO ☐ YES

IS HEPATITIS C VIRAL LOAD KNOWN? (For genotype requests only) ☐ NO ☐ YES, DATE OF VIRAL LOAD TEST: ______________________

VIRAL LOAD RESULT: ______________ IU/ml ______________ RNA copies/ml

## 8. Additional Comments

## 9. Submitter Information (Required for transmission of laboratory report) **required information*

| * SUBMITTER NAME (Name of person authorized to order clinical test ) | | LICENSE NUMBER OF PROVIDER ORDERING TEST |
|---|---|---|
| * FACILITY | | ATTN TO: (If different from person ordering test) |
| * STREET ADDRESS | | * TELEPHONE NUMBER |
| STREET ADDRESS | | FAX NUMBER |
| * CITY | * STATE | * ZIP CODE |

## SUBMITTING SPECIMENS TO THE BLOODBORNE VIRUSES LABORATORY
## WADSWORTH CENTER, NEW YORK STATE DEPARTMENT OF HEALTH

**Specimen collection kit:** Specimen collection kits can be obtained by calling the NYSDOH Wadsworth Center Order Desk at **(518) 474-4175**. These kits include requisition form DOH-49, lavender-top EDTA blood collection tubes, and materials for packing and shipping whole blood specimens at room temperature. For shipping specimens on cold packs or dry ice, submitters must provide insulated shipper and other supplies.

**Requisition form:** Fill in the requisition form (DOH-49) as completely as possible, including test requested and all required fields. For transgender individuals, please indicate gender at time of testing. Include previous test results and other clinical information that may help us to interpret results. Please write legibly. Fillable requisition forms can be obtained on our website – **www.wadsworth.org/divisions/infdis/hiv/index.html**.

**Specimen labeling:** Label each specimen with two unique identifiers (name, date of birth, patient number). These identifiers must match the requisition form exactly. A unique identifying code may be used for anonymous HIV testing; however this testing may only be requested from NYSDOH-approved anonymous testing sites.

**Specimen collection and shipping:** See table for collection and shipping instructions for preferred specimen types. Collect a full tube to allow all necessary tests to be completed. Contact the lab at **518-474-2163** for instructions for submitting other specimen types (e.g. dried blood spots, blood tubes not specified below). Package tubes according to the directions supplied with the specimen mailing kit or according to IATA regulations. We recommend sending specimens by courier; U.S. Postal Service shipping is not recommended. The laboratory receives specimens Mon – Fri; please ship with this in mind.

| Test requested | Specimen collection (plastic tubes only) | Specimen processing | Specimen shipping |
|---|---|---|---|
| HIV diagnostic<br>HIV rapid test confirmation<br>HIV-1 qualitative RNA<br>HIV- defendant<br>HIV-2 qualitative RNA<br>HCV Ab - reflex to RNA<br>HCV RNA testing only | **EDTA Plasma:** Collect blood in 9ml lavender-top EDTA tube and invert gently 8-10 times. | **Whole blood:** none | **Whole blood:** ship at room temperature; lab must receive within **72 hrs** of collection. |
| | | **Plasma:** Centrifuge at 1000-1300x g for 10 min. Transfer plasma into labeled sterile plastic vial. | **Plasma:** store at 2-8°C and ship in insulated shipper on cold packs*; lab must receive within **7 days** of collection. |
| HIV-2 viral load<br>HCV viral load | **EDTA Plasma:** Collect blood in 9ml lavender-top EDTA tube and invert gently 8-10 times. | Centrifuge at 1000-1300x g for 10 min within 6 hrs of collection. Transfer plasma into labeled sterile plastic freezer vial and freeze before shipping. | **Plasma:** Ship frozen specimen on dry ice in an appropriate container according to IATA regulations*. Ship by courier for next-day delivery. |
| HCV genotyping | **EDTA Plasma:** Collect blood in 9ml lavender-top or white-top PPT tube containing EDTA and invert gently 8-10 times.<br>**Serum:** Collect blood in 9ml red-top or gold-top SST tube and invert gently 5 times. Allow to clot 30-60 min. | Centrifuge at 1000-1300x g for 10 min within 6 hrs of collection. Transfer plasma or serum into labeled sterile plastic freezer vial and freeze before shipping. If using PPT or SST tubes, sample may be frozen & shipped in collection tube after centrifugation. | **Plasma or serum:** Ship frozen specimen on dry ice in an appropriate container according to IATA regulations.* Ship by courier for next-day delivery. |

* Submitters must provide insulated shipper and other supplies for shipping specimens on cold packs or on dry ice.

**Shipping address:**

**Bloodborne Viruses Laboratory**
**David Axelrod Institute**
**Wadsworth Center-NYSDOH**
**120 New Scotland Avenue**
**Albany, NY 12208**
**(518)-474-2163**