Requirements and Instructions for Submitting Pediatric Specimens to the Wadsworth Center for Diagnostic HIV Testing

The Pediatric HIV Testing Service was implemented by the New York State Department of Health (NYSDOH) to assist in the diagnosis of perinatal HIV transmission. *This service is not intended as a screening program for HIV, but rather as a diagnostic testing service to definitively diagnose or exclude HIV infection in infants who are known to be HIV antibody positive or whose mothers are known to be positive.* HIV infection can reasonably be excluded among HIV -exposed children with two or more negative nucleic acid tests (NAT) performed at greater than one month of age and one of those being performed at or greater than four months of age. An infant is diagnosed as infected at any age by two positive nucleic acid tests performed on separate specimens.

The NYSDOH recommendations for diagnosis of pediatric HIV infection in HIV-exposed infants are written, reviewed and updated on a regular basis by the New York State Committee for Care of Children and Adolescents with HIV Infection. Please consult www.hivguidelines.org for the most recent update.

Obtaining test kits:

- Test kits, which include a requisition, collection tube, mailing and shipping supplies, can be obtained through the State Order Desk and should be kept stocked in either the physicians' office or clinic. Specimen collection and shipping kits can be ordered by calling the order desk at **(518) 474-4175**.

Obtaining and labeling specimens:

- The whole blood specimen should be collected in the EDT A (lavender top) tube supplied with the kit. *The preferred specimen is a full tube.* This volume will permit the performance of HIV nucleic acid testing as well as HIV antibody testing and any additional HIV testing that is indicated.
- **The specimen tube must be labeled with the patient name and collection date.** *Failure to properly label the sample will result in rejection of the specimen as "unsatisfactory" and a request will be made for another specimen.*
- Please consult with the Testing Service or a neonatologist on the specimen volume for premature infants.

Completing the requisition form:

- Complete the Bloodbome Viruses Laboratory Pediatric HIV Testing Requisition (DOH-3917) supplied with the specimen kit. The requisition form should be completed in full. **The following information is required and failure to provide this information may delay testing and/or reporting:**
  - Infant name, date of birth, birth facility, and date of collection.
  - Full name, complete address, NYS license number and phone number of the person authorized to order the test.

Shipping samples:

- Samples must be packaged and shipped according to the instructions in the diagnostic specimen mailer *on the day they are drawn and mailed in the specimen mailers provided via express mail.*
- Specimens collected on Fridays, weekends or holidays will be processed on the next NYS business day. **Collection of specimens on a Friday preceding a Monday holiday is not recommended.**

Questions concerning diagnostic testing of HIV-exposed infants can be answered by calling:
Bloodborne Viruses Laboratory: Phone (518) 474-2163

More information is available at www.wadsworth.org/divisions/infdis/hivlindex.html

FOR LAB USE ONLY: NYS Accession Number: Record I.D. Number:

NEW YORK STATE DEPARTMENT OF HEALTH

Wadsworth Center
David Axelrod Institute
120 New Scotland Avenue
Albany, NY 12208

Bloodborne Viruses Laboratory
Pediatric HIV Testing Requisition

1. Please indicate if this is an initial or follow-up test

☐ INITIAL TEST (0-48 HOURS RECOMMENDED)

☐ FOLLOW-UP TEST (PLEASE INDICATE TIME FRAME): ☐ 2 WEEKS ☐ 4-6 WEEKS ☐ 4-6 MONTHS

2. Collection Date

MO / DAY / YR

3. Patient Name and Information

PATIENT'S LAST NAME	PATIENT'S FIRST NAME

HAS PATIENT BEEN TESTED UNDER ANY OTHER NAME? IF YES, LIST NAME(S)

PATIENT CODE	HOSPITAL MEDICAL RECORD #	NEWBORN SCREENING LAB I.D.

4. Patient Demographics

GENDER	DATE OF BIRTH	AGE	BIRTHWEIGHT (GMS)	GESTATION (WEEKS)
☐ MALE ☐ FEMALE	MO / DAY / YR			

RACE (SELECT ONE OR MORE)

☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE

☐ ASIAN ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER

ETHNICITY (SELECT ONE)

☐ HISPANIC OR LATINO

☐ NOT HISPANIC

NAME OF BIRTH FACILITY	STATE OF BIRTH	COUNTY OF BIRTH
COUNTY OF RESIDENCE	ZIP CODE OF RESIDENCE	IS CHILD IN FOSTER CARE? ☐ YES ☐ NO

5. Treatment History

WERE ANTIRETROVIRALS GIVEN TO THE MOTHER? ☐ YES ☐ NO ☐ UNKNOWN IF YES, LIST DRUG(S) ____

IF ANTIRETROVIRALS WERE GIVEN TO THE MOTHER, WHEN WERE THEY GIVEN? ☐ DURING PREGNANCY AND DELIVERY ☐ PREGNANCY ONLY ☐ DELIVERY ONLY

WERE ANTIRETROVIRALS GIVEN TO THE INFANT? ☐ YES ☐ NO ☐ UNKNOWN IF YES, LIST DRUG(S) ____

6. Additional Comments

7. Submitter Information (Required for transmission of laboratory report)

SUBMITTER NAME (Name of person authorized to order clinical test)	LICENSE NUMBER OF PROVIDER ORDERING TEST	
ATTENTION TO: (If different from person ordering test)	TELEPHONE NUMBER	
STREET ADDRESS	FAX NUMBER	
STREET ADDRESS	BUILDING / ROOM NUMBER	
CITY	STATE	ZIP