Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Coláiste na hOllscoile Corcaigh, Éire
University College Cork, Ireland

Ospidéal Ollscoile Chorcaí
Cork University Hospital

PAEDIATRIC

Human Immunodeficiency Virus (HIV) PCR Test Request and Report Form

Please refer to the MVDRL Service Users Manual for test information which is available on-line*.

SPECIMEN: Minimum volume 1.5 mL Plasma

Patient Details

Attach Addressograph Label In This Section Only

Hospital No: _____ **DOB:** _____

Surname: _____ **Gender:** Female ☐ Male ☐

First name: _____ **HIV proviral request?** Yes ☐ No ☐ *If yes, please contact lab*

Address: _____ **Date of test request:** _____

Initial of Authorising Physician (AP): _____ **Form completed by (if different to AP):** Initial: _____

Maternal details

Maternal surname: _____ **First name:** _____

Maternal Hospital No: _____ **DOB:** _____

Clinical Details

Anti-viral therapy: Yes ☐ No ☐ **Start date:** _____

Therapy/other details: _____

FOR LABORATORY USE ONLY

HI test number: **HI** HIV HIV

Receipt: Initial

Type: Plasma ☐ Frozen ☐

Laboratory Investigation Results

HIV status:

HIV **not** detected ☐ | **HIV detected** (less than **20** copies/mL) ☐ | **HIV detected** (greater than **100,000** copies/mL) ☐

Quantitative value: *Sample viral load* _____ ☐ viral copies/mL ☐ Log_{10} viral copies/mL

Comments: _____ **Request another sample:** ☐

Affix CTM Sticker Here

Sample dilution details: _____

Authorised by[1]: _____ **Date:** _____

[1]**Liam Fanning, PhD, DSc. Director, MVDRL.**

MVDRL