DNA PCR REQUISITION FORM

Office Stamp

Sample Information

Reason for test ☐ Initial / first time ☐ Repeat / confirmatory

Type of sample: ☐ DBS ☐ EDTA whole blood

Date sample collected (DD/MM/YY) : ____ / ____ / ____

Date sample shipped to PCR Lab (DD/MM/YY) : ____ / ____ / ____

Infant Testing History (NB- if >1 prior test completed, provide information for most recent test)

Any prior HIV test?	If "Yes", Type of test:	Previous NHL/PHL Lab ID (if present): _____
☐ Yes ☐ No	☐ DNA PCR ☐ HIV Ab - Serology	Test Result : _____ Date of Test (DD/MM/YY) : ____ / ____ / ____

Facility Information

State/Region: _____ Township: _____

Level of Facility: ☐ AIDS/STD team ☐ District/Township/General Hospital ☐ Specialist Hospital

☐ INGO: _____ ☐ Others (please specify): _____

Mother/Guardian's General Information

Name: _____ Residing State/Region: _____ Residing Township: _____

PMCT Code : _____ Telephone number : _____

Infant's General Information

Name: _____ Date of Birth (DD/MM/YY): ____ / ____ / ____ Sex : ☐ Male ☐ Female

Mother/Father Information (Consult Mother's ANC Card/Book)

a) Mother HIV Status	b) Father HIV Status	c) Mode of Delivery	d) Maternal ARV Status	If "Initiate ARV during pregnancy", Week Started:
☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown	☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown	☐ Vaginal ☐ Elective Caesarean ☐ Emergency Caesarean	☐ Initiate ARV during pregnancy ☐ Initiate ARV during delivery ☐ Initiate ARV after delivery ☐ Known case on ART ☐ None	_____

Infant PMCT

a) ARV status	b) Feeding History
☐ Daily NVP 4-6wks ☐ Daily NVP & AZT 4-6wks ☐ None	Currently Breastfed ☐ Yes ☐ No If **Yes**, Exclusive Breast Feeding : ☐ Yes ☐ No ☐ Unknown Exclusive Replacement Feeding : ☐ Yes ☐ No ☐ Unknown Mixed Feeding : ☐ Yes ☐ No ☐ Unknown If **No**, Age when last breastfed: _____months

Signature :

Name of Doctor / Health Staff : _____

Name of Hospital / ART Site / AIDS STD Team : _____

Telephone No. : _____

Please send the result back to the following Hospital/ ART Site/ AIDS-STD Team: _____

Only for PCR Lab	Lab ID: _____ Date of sample received: _____ Date of registration: _____	Quality of Specimen ☐ Accept ☐ Reject If "Reject", Reason: _____	Signature : Name :