NATIONAL REFERENCE LABORATORY for HIV/AIDS, Hepatitis B/C & Other STIs

San Lazaro Hospital-STD AIDS Cooperative Central Laboratory

Quiricada St., Sta. Cruz, Manila Tel Nos: (632)3109528 to 29, Fax No: (632)711-4117

Email: nrlslhsaccl@yahoo.com.ph Website: www.nrlslhsaccl.com.ph

CHECK ONE:

- ☐ HIV Antibody
- ☐ HIV Nucleic Acid Test
- ☐ SYPHILIS
- ☐ Hepatitis C Antibody
- ☐ HCV Nucleic Acid Test
- ☐ HBsAg Neutralization Assay Test

CONFIRMATORY REQUEST FORM

PATIENT DATA

Patient Name (Please use comma after surname) *Surname* *First Name* *M.I.* *Age:* *Sex:* ☐ M ☐ F

Birthdate (mm/dd/yyyy) : | *Nationality:* | *Civil Status:* | *Occupation:*

History of travel abroad within the past 12 months ☐ No ☐ Yes (please indicate country visited) _____ | *Blood type / Rh:*

Check specimen type: (check) ☐ serum ☐ plasma ☐ blood unit | *Date blood collected* Date / / Time :

Sample storage condition prior to transport: ☐ 4°C (refrigerator) ☐ -20°C (freezer) ☐ room temperature | *Date blood transported:* Date / / Time :

Unique Identifier Code (UIC) *for HIV referral only*	*First 2 letters of Mother's Name*	*First 2 letters of Father's Name*	*Patient's Birth Order*	*Patient's Month of Birth*	*Patient's Year of Birth*
	_____ _____	_____ _____	☐ 1st ☐ 2nd ☐ Others _____		

For NRL-SACCL USE ONLY

barcode sticker

Date & Time/ Form Received By:

Date & Time/ Sample Extracted By:

OR/AMOUNT PAID:

PATIENT ID:

Remarks:

TEST RESULTS

(Any test format) **Test- I**

Complete commercial name of assay:

Manufacturer:

Assay Lot #:

Model of equipment (reader) used:

	Test run date/s	RAPID TEST: (Reactive, Nonreactive or Inconclusive)	IMMUNOASSAY	
			Cut-off value	Absorbance or S/CO:
Run 1				
Run 2				

(Any test format) **Test - II**

Complete commercial name of assay:

Manufacturer:

Assay Lot #:

Model of equipment (reader) used:

	Test run date/s	RAPID TEST: (Reactive, Nonreactive or Inconclusive)	IMMUNOASSAY	
			Cut-off value	Absorbance or S/CO:
Run 1				
Run 2				

INSTRUCTIONS:

1. Completely fill out NRL-SLH/SACCL Confirmatory Request Form. Disregard Test-II if only one test format (brand) was used.
2. Serum/plasma samples should be transferred to a 2 ml cryovial prior to transport. Specimens must be **PROPERLY** labeled (ie. name & date of birth).
   - Minimum of 1.5ml sample is required.
   - In case of delay, serum/plasma samples may be stored at 4°C for 7 days (- 20°C for > 7 days).
   - If stored at 4°C, ship with ice pack/cold dog.If stored at -20°C or lower, ship with dry ice.
3. Submit this form and sample to NRL-SLH/SACCL or by courier to this address: *Receiving Section – NRL-SLH/SACCL Annex, Bldg 17, San Lazaro Hospital Compound Quiricada St., Sta. Cruz, Manila*

*For HIV referrals, submit the Personal Information Sheet DOH-EB Form A together with this Confirmatory Request Form.

*ONLY HIV confirmatory testing is FREE and results will be available after 10 (working) days for samples that meet NRL's Specimen Acceptance Criteria.

*For children below 18 months old, submit NRL's Confirmatory Request Form, EB - Form A, EB - A-MC Form and Mother's HIV Confirmatory Result.

*For further information on referral requirements visit our website or call NRL-SLH/SACCL.

LAB DATA

Referring laboratory: | *Medical Technologist: (Print Name)* | *Signature:*

Address: | *HIV Proficiency #:* (For HIV Referrals) | *Mobile #*

Tel/Mobile No. *Fax:* *e-mail:* | *Pathologist / Laboratory Chief: (Print Name)* | *Signature:*

CONTROLLED