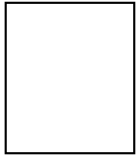




IMMUNOPHENOTYPING REQUEST FORM



Queue #

Date Requested : _____

Name/ Patient Code: _____

Age/ Sex: _____ Birthdate (MM/DD/YY): _____

Address: _____

Contact Number: _____

ID Presented/ ID Number: Government _____ Private _____

Check Examination Desired: () CD4 Count
 () Others _____

Reason: () Baseline Test
 () Monitoring, indicate below
 Previous CD4 count _____ cells/ul; date tested _____

ARV History: Date Started _____
 ARV Regimen _____
 Date HIV confirmatory test was done _____

Risk Factor: () Heterosexual () Homosexual () IDU () Unknown
 () Sex worker () other/s _____

 Specimen Extracted By (Signature over printed name)

 Signature over printed name of referring physician

 Date/ Time of Extraction

 Organization/ Affiliation/ Hospital

 Laboratory Number

 Amount/ OR Number/ CS Number
 Bill to : Patient Philhealth FOC

Received By: _____ (Signature over printed name)	Date & Time: _____
Tracking: <input type="radio"/> Receiving _____ <input type="radio"/> Billing/ Cashier _____ <input type="radio"/> Extraction _____	

