Republic of the Philippines
Department of Health
NATIONAL REFERENCE LABORATORY for HIV/AIDS, Hepatitis B/C & Other STIs
San Lazaro Hospital-STD AIDS Cooperative Central Laboratory
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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: ( ) Heteroxesual ( ) 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: ◯ Receiving _____ ◯ Billing/ Cashier _____ ◯ Extraction _____	

NATIONAL REFERENCE LABORATORY
SAN LAZARO HOSPITAL
STD-AIDS COOPERTIVE CENTRAL LABORATORY
CONTROLLED
Signature Date