Date Received ______/___/___ YYYY/MM/DD

Requisition #

Patient addressograph

Patient Information *This must be completed at every visit*

Ontario HIN __/__/__/__/__/__/__/__/__/__/__/ version __/__

Surname __________________ First Name __________________ Initial ______

Date of Birth (YYYY/MM/DD) ___________________________ Sex M/F Pregnant No/Yes

Ordering Physician Information

Phys # __/__/__/__/__/__/__/ - __/__

Name:

Address:

cc. Dr.______________________________________

Address:

Telephone: Fax: Physician Signature___________________________ Date ______/___/___ YYYY/MM/DD

Treatment Information ***This information is essential for the interpretation of test results and for the continuation of the program***

- ❑ Baseline
- ❑ Follow-up

Most recent CD4+ T-Cell Count:

Result: ______ cells/mm3 ________% Date performed_____/____/__ YYYY/MM/DD

Current Anti-retroviral Durg Regimen

Generic	Trade	Abbr.	Date Started(YYYY/MM/DD)
❑ No therapy			
❑ Abacavir	Ziagen	ABC	__________________________
❑ Abacavur + zidovudine + Lamivudine	Trizivir	ABC + AZT + 3TC	__________________________
❑ Amprenavir	Agenerase	APV	__________________________
❑ Atazanavir	Reyataz	ATZ	__________________________
❑ Didanosine	Videx	ddI	__________________________
❑ Delavirdine	Rescriptor	DLV	__________________________
❑ Efavirenz	Sustiva	EFZ	__________________________
❑ Indinavir	Crixivan	IDV	__________________________
❑ Lamivudine	Epivir	3TC	__________________________
❑ Lamivudine/zidovudine	Combivir	3TC-AZT	__________________________
❑ Lopinavir/ritonavir	Kaletra	LPV	__________________________
❑ Nelfinavir	Viracept	NFV	__________________________
❑ Nevirapine	Viramune	NVP	__________________________
❑ Ritonavir	Vorvir	RTV	__________________________
❑ Saquinavir-H3	Invirase	SQV (HGC)	__________________________
❑ Saquinavir-SG	Fortovase	SQV (SGC)	__________________________
❑ Stavudine	Zerit	d4T	__________________________
❑ Tenofovir	Viread	TDF	__________________________
❑ Zalcitabine	Hivid	ddC	__________________________
❑ Zidovudine	Retrovir	AZT, ZDV	__________________________
❑ Others	____________		__________________________

Collection Information ***This information must be filled out at the time of collection to ensure result integrity***

Collected ______/___/___ YYYY/MM/DD ____/_____ am pm initials ____ HR/MIN Plasma separated ___/___ am pm initials _____ HR/MIN

Received ______/___/___ YYYY/MM/DD ____/_____ am pm initials ____ HR/MIN Frozen (<-20 °C) ___/___ am pm initials _____ HR/MIN

Viral Load

Ministry of Health and Long-Term Care, Ontario Public Health Laboratory

REQUISITION for HIV VIRAL LOAD MONITORING