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CPA

Accredited Medical Laboratory
Reference No: 1926

HIV Drug Resistance Request Form

Acceptable samples: EDTA plasma or serum, minimum sample volume 500 µl

Test requested: Please tick

☐ **HIV-1 integrase drug resistance**

☐ **HIV-1 protease/ reverse transcriptase drug resistance**

Patient details

Name/ID:

D.O.B.:

Gender: Male / Female

Hospital No.:

Name and address for results:

Contact phone no.:

Secure fax no. for results:

Sample details

Sample type:

Lab. No.:

Date & time sample collected:

Viral load

Date of viral load:

Clinical information

Country of origin of infection:

Ethnic origin of patient: White/Black/Asian/Other

Is this patient pregnant? YES / NO

Does this patient have AIDS? YES / NO

Is this patient treatment naïve? YES / NO

Relevant Drug History:

Please supply the contact details of your finance department for invoicing.