

**NOTIFICATION OF LABORATORY TESTING RESULTS
INDICATIVE OF HUMAN IMMUNODEFICIENCY VIRUS (HIV)
BY LABORATORY TO
LOCAL HEALTH DEPARTMENT**

LABORATORY REPORT NUMBER*
(Specimen Accession Number or Other Unique Specimen Identifier)

PATIENT INFORMATION			DATE SPECIMEN TESTED*		
FIRST NAME*:		LAST NAME*:	____/____/____ MM DD YYYY		MIDDLE NAME:
DATE OF BIRTH*: ____/____/____ MM DD YYYY			PATIENT ADDRESS		
GENDER*: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Male-to-Female Transgender <input type="checkbox"/> Female-to-Male Transgender			CITY		STATE
RACE: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> Unknown			PHONE ()		
LATINO: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			SOCIAL SECURITY NUMBER: ____ - ____ - ____		
			MEDICAL RECORD NUMBER: _____		
PROVIDER*			LABORATORY*		
PROVIDER NAME			CLIA#		
ADDRESS			LAB NAME		
CITY	STATE	ZIP CODE	ADDRESS		
PHONE ()			CITY	STATE	ZIP CODE
MD's Name: _____			PHONE: () _____		
HIV Antibody Tests (Non-type differentiating)		Sample Type: <input type="checkbox"/> Blood <input type="checkbox"/> Saliva <input type="checkbox"/> Urine <input type="checkbox"/> Other <input type="checkbox"/> Unk		Manufacturer:	
TEST 1: <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 IA <input type="checkbox"/> HIV-2 WB Other: Specify Test: _____					
RESULT 1: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate <input type="checkbox"/> RAPID TEST (check if rapid) Collection Date: ____/____/____					
TEST 2: <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 IA <input type="checkbox"/> HIV-2 WB Other: Specify Test: _____					
RESULT 2: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate <input type="checkbox"/> RAPID TEST (check if rapid) Collection Date: ____/____/____					
HIV Antibody Tests (Type differentiating)		Sample Type: <input type="checkbox"/> Blood <input type="checkbox"/> Saliva <input type="checkbox"/> Urine <input type="checkbox"/> Other <input type="checkbox"/> Unk		Manufacturer:	
TEST: <input type="checkbox"/> HIV-1/2 Differentiating (e.g., Multispot)					
RESULT: <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (undifferentiated) <input type="checkbox"/> Neither (negative) <input type="checkbox"/> Indeterminate Collection Date: ____/____/____					
HIV Detection Tests (Qualitative)		Sample Type: <input type="checkbox"/> Blood <input type="checkbox"/> Saliva <input type="checkbox"/> Urine <input type="checkbox"/> Other <input type="checkbox"/> Unk		Manufacturer:	
TEST: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-1 P24 Antigen <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-2 Culture					
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Collection Date: ____/____/____					
HIV Detection Tests (Quantitative viral load)		Sample Type: <input type="checkbox"/> Blood <input type="checkbox"/> Saliva <input type="checkbox"/> Urine <input type="checkbox"/> Other <input type="checkbox"/> Unk		Manufacturer:	
TEST: <input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative viral load) Collection Date: ____/____/____					
RESULT: <input type="checkbox"/> Undetectable, < _____ Copies/mL or <input type="checkbox"/> Detectable: _____ Copies/mL; _____ Log					
Immunologic Tests (CD4)		Count: _____ cells/µL Percentage: _____% Collection Date: ____/____/____			
HIV-1 Genotype Tests [Nucleotide Sequence]		<input type="checkbox"/> PR <input type="checkbox"/> RT <input type="checkbox"/> PR/RT <input type="checkbox"/> IN <input type="checkbox"/> PR/RT/IN		Collection Date: ____/____/____	

Because of severe penalties written into the law for breaches in security and confidentiality, we strongly suggest you **NOT email or fax** laboratory reports of HIV-indicative results to us. HIV reports can be sent by traceable mail or courier services to:

Los Angeles County Department of Public Health
600 South Commonwealth Avenue, 10F - Suite 1260
Los Angeles, CA 90005
Tel: (213) 351-8196 or (213) 351-8516

*Minimum information required for HIV reporting