

**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*		_____	
					MM/DD/YYYY	
FIRST NAME*:	_____	LAST NAME*:	_____	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	ZIP CODE
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			
HISPANIC: <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:	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