Form 197
Revised 9/2018

"This form when filled in contains patient information that must be protected in accordance with the Health Insurance Portability Accountability Act."

KY Division of Laboratory Services
100 Sower Blvd. Suite 204
Frankfort, Kentucky 40601
Phone: 502/564-4446 Fax: 502/564-7019

Please complete a separate form for each specimen.

Kentucky Public Health
Prevent. Promote. Protect.

Human Immunodeficiency Virus Serology

PATIENT INFORMATION:

Name (Last, First, MI)

Social Security # Sex Race Age Birthdate

Home Address

City State Zip Code County

Send Report To:

Submitter

Street Address (PO BOX)

City State Zip Code

Specimen Information:

Specimen type: ☐ Serum ☐ Whole Blood ☐ Other _____

Date of Collection _____

Program: Has patient been previously tested: ☐ Yes ☐ No

If yes, when *(date)* _____ :previous results: ☐ Negative ☐ Positive ☐ Indeterminate

Reason For Testing: (*Mark One*)

Counseling-Testing Site Volunteer
- ☐ Confidential
- ☐ Anonymous

Maternal & Child Health Clinic Patient
- ☐ Symptoms suggest HIV Infection
- ☐ Risk factors for HIV Infection

- ☐ TB Patient
- ☐ STD Clinic
- ☐ Person in Custody of Social Services
- ☐ Needlestick Injury
- ☐ Other (prior approval required) _____

Laboratory Findings:

Specimen Unsatisfactory:

☐ Broken in transit ☐ Chylous ☐ Hemolyzed
☐ Insufficient quantity ☐ Laboratory Accident ☐ Other _____

ELISA- Enzyme-Linked Immunosorbent Assay Test:

☐ Non-reactive: No p24 antigen or antibodies to HIV-1/HIV-2 detected
☐ Repeatedly reactive: Supplemental testing required

Confirmatory Test Performed: Geenius

☐ Non-reactive: HIV (1 or 2) antibodies are not detected
☐ Reactive: Antibody to HIV-1 detected
☐ Reactive: Antibody to HIV-2 detected
☐ Indeterminate: Testing inconclusive- Please submit an additional specimen as clinically indicated or in six weeks per CDC guidelines

Date Received:	Laboratory Number:	Date Reported:	Technologist: