

[INSERT PRACTICE NAME]

Laboratory Request

Patient Name _____ Date _____

DOB _____ DX Code _____

The above patient has been counseled regarding the ordered tests and has given his or her consent for the ordered tests to be performed. This patient has had the opportunity to ask questions regarding the tests. The patient has been informed that if the test is positive that it will be reported to the NC Health Department as mandated by law.

First Visit

Chronic Visits every 3-4 months

- HIV ELISA
- HIV Ultra Sensitive Viral Load LabCorp #550483
- Quant. B-DNA Assay
- CD4 count / %
- CBC with Diff.
- CMP
- CMV IgM / IgG
- RPR
- Toxo IgG
- G6PD
- Chronic Hep A, B, C Panel
- HIV Genotype

- HIV Ultra Sensitive Viral Load
- CD 4 / %
- CBC
- CMP

Other Labs Tests

Please fax all results to 910-763-6608 and / or mail to 2310 Delaney Avenue, Wilmington, NC 28403. Office phone is 910-763-4511. Office Hours are 9-5 Monday thru Friday.

Ordering Physician: _____