CENTER FOR HUMAN VIROLOGY AND GENOMICS

M0588

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Healthcare/Clinician ☐ **Walk in** ☐

Receipt number …… Date …… CHVG Code: ……..

Surname …….. First name ……..

Address …….
Phone number ……...

DOB: ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY Sex M/F ☐

Marital status: (a) Single (b) Married (c) Divorced (d) Separated (e) Widowed

Name of Healthcare Provider/clinician ……

Address…….

Phone number……. Time of primary sample collection----------

Type of Primary Sample…….Date of primary sample collection----------
Diagnosis/clinical details……**Anatomic site of sample collection……**

Tests Requested (Tick as apply)

Immunology/Haematology
☐ CD4 Count
☐ FBC

Serology
☐ HIV Confirmation*
☐ Hepatitis BsAg*
☐ Hepatitis BeAg
☐ Hepatitis BsAb
☐ Hepatitis BeAb
☐ Hepatitis BcIgM
☐ Hepatitis C Ab *

Chemistry
☐ FBS
☐ 2HPP
☐ Creatinine
☐ Urea/BUN
☐ Bilirubin Direct
☐ Biliubrin Total
☐ ALP
☐ AST
☐ ALT
☐ GGT
☐ Total Protein
☐ Albumin
☐ Cholesterol
☐ LDL
☐ HDL
☐ Triglycerides
☐ Bicarbonates
☐ Glucose
☐ Sodium
☐ Potassium
☐ Chloride

Molecular Diagnostics
☐ Hepatitis B Viral Load*
☐ Hepatitis C Viral Load*
☐ HIV-1 Viral Load*
☐ HIV-1 DNA PCR*
☐ HIV-1 Drug Resistance Testing *
Last(1 Month) VL---------
☐ HPV –only on request.
☐ COVID-19
☐ Sequencing

Note1:"Tests Marked with asterisked "*" are SANAS Accredited " in this request form.

Indicate how result will be sent (Tick as apply): ☐ Email; ☐ Pick-up.
Note 2: "Please write your email address legibly with capital letters."
Email Address……
Note 3: Please note that a consent form is available for your review.

For CHVG Use only
Received/Bled by……..... Date…… Time…….. ……..
Type of sample tubes used: EDTA ☐ Clot activator ☐ Plain ☐ fluoride oxalate ☐

Note 4: Result not picked after 2 months from the due date, will be invalid.