

IOWA CONFIDENTIAL LABORATORY REPORT OF HIV TEST RESULTS

(Please print) Last Name of Client		First Name		Middle Name/Initial		Date of Birth ____/____/____ (mm) (dd) (yyyy)		Sex ☐ M ☐ F		Pregnant? ☐ No ☐ Yes _____ no. of weeks	
Marital Status ☐ S ☐ M ☐ D ☐ Sep ☐ Unk ☐ Widow ☐ Cohabitation			Race ☐ Am Ind ☐ Asian ☐ Black ☐ White ☐ Unk ☐ Hawaiian/Pac Islander ☐ Refused			Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unk ☐ Refused					
Street Address				City		State		Zip Code		Telephone (Include Area Code)	
Name and CLIA Code of Laboratory				Person Completing Form Printed Name _____ Signature _____				Date of Report ____/____/____ (mm) (dd) (yyyy)			
Street Address				City		State		Zip Code		Telephone (Include Area Code)	
Name of Physician/ Provider Who Ordered the Test(s)						Name of Facility					
Street Address				City		State		Zip Code		Telephone (Include Area Code)	
Specimen Type				Instructions: (1) Select all lab results that apply. (2) For tests not done in house, please attach copy of results from lab that performed the test.							
POSITIVE HIV Antibody Tests (Non-type differentiating) [HIV-1 vs. HIV-2] ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB Collection Date: ____/____/____ Result Date: ____/____/____											
POSITIVE HIV Antibody Tests (Type differentiating) [HIV-1 vs. HIV-2] (e.g., Geenius or Multispot) ☐ HIV-1 ☐ HIV-2 ☐ Both (undifferentiated) ☐ Neither ☐ Indeterminate Collection Date: ____/____/____ Result Date: ____/____/____											
HIV Detection Tests (Qualitative) ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV-1 P-24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (Qual) ☐ HIV-2 Culture Result: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate Collection Date: ____/____/____ Result Date: ____/____/____											
HIV Detection Tests (Quantitative viral load) ☐ HIV-1 RNA/DNA (Quantitative viral load) Limit of detection (Copies/mL _____) Result: ☐ Detectable ☐ Undetectable Copies/mL _____ Collection Date: ____/____/____ Result Date: ____/____/____											
Immunologic Tests (CD4 count and percentage) CD4 count: _____ cells/μL CD4 %: _____% Collection Date: ____/____/____ Result Date: ____/____/____											
► IOWA CODE REQUIRES A REPORT WITHIN 7 DAYS OF RECEIPT OF A TEST RESULT FOR ANY OF THE TESTS LISTED ABOVE ◀											
** PLEASE ATTACH COPIES OF THE LABORATORY TEST RESULTS **											
Mark envelope "CONFIDENTIAL 03" and mail to: Iowa Department of Public Health 321 East 12th Street Des Moines, IA 50319				► FAX COMPLETED FORM AND RESULTS TO 515-725-1278 ◀ ► Call (515) 322-8819 or (515) 721-8486 ◀				Questions? Call (515) 322-8819 or (515) 721-8486			