STATE OF MARYLAND HIV/CD4 Laboratory Reporting Form

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	Lab Accession #:]	
	Medical Record #:				
	Patient Name:				
	First Last Patient Address: (Please print)	MI			
Address					
	Address Apt.	Apt.			
	City State ZIP Code			—	
Last 4 SSN# Date of Birth (MMDDYYYY) Sex 1 = Male 2 = Female 9 = Not specified					
	Ethnicity Hispanic Race American Indian or Alaska Native Native Hawaiian or other Pacific Islander (Check one) Not Hispanic (Check all that apply) Asian Black or African American White Unknown				
	Specimen Collection Date 1 = Blood (MM/DD/YYYY) Specimen Type 3 = Serun 3 = Serun	na 5=0	ral Fluid		
	TEST PERFORMED/RESULT				
	HIV + (Check all that apply) CD4 I HIV-1 Western Blot: I Positive IFA: I Reactive P24 Antigen: I Reactive I HIV-2 I percent				
Viral Load: copies/ml Undetectable					
	Type: NASBA (Organon) RT-PCR(Roche) bDNA(Chiron) Image: Other (specify) Image: Other (specify) Image: Other (specify)			,	
ORDERING PHYSICIAN Name: Last First Last Phone #: Image: Im				_	
				_	
	Address: (Please print)				
	Building or Facility Name				
	Address Suite/Room	Address			
	City State ZIP Code TESTING LABORATORY				
	CLIA # Sent to CLIA # Sent to CLIA #				
	Date Form Completed Person Completing Form			=	