HIV Genotyping Resistance Testing

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LAB NO:

Please write clearly in black ink

SENDER'S INFORMATION

Sender's name and address:

Phone: Ext:

PATIENT/SOURCE INFORMATION

RN: Hospital name (if different from sender's name):

Name: Ward/Clinic name:

Sex ☐ Male ☐ Female

Date of birth: Age:

SAMPLE INFORMATION

Sample type ☐ Plasma

Consent for leftover sample to be used in other assays?

☐ Yes ☐ No

Date and time of collection:

Date sent to IMR:

TEST REQUESTED

HIV Genotyping Resistance Testing

☐ RT and Protease

CLINICAL /EPIDEMIOLOGICAL INFORMATION

Reason for test

- ☐ New diagnosis
- ☐ Treatment failure
- ☐ Poor response to new regime
- ☐ Starting ART 1st time
- ☐ Re-starting ART after drug interruption
- ☐ Acute primary infection seroconverter
- ☐ Pregnancy
- ☐ Other (Please specify)

Adherence

- ☐ Poor
- ☐ Excellent
- ☐ Reasonable
- ☐ No opinion

Most recent viral load at time of sample .....copies

Date of most recent viral load

Patient on therapy when sample was taken? ☐ Yes* ☐ No

Has patient ever on therapy? ☐ Yes* ☐ No

***Details of Current/Previous Therapies:**

NRTIs	current/ most recent	Previous	**PIs**	current/ most recent	Previous
ZDV	☐	☐	APV	☐	☐
D4T	☐	☐	fosAPV	☐	☐
ddI	☐	☐	ATV	☐	☐
3TC	☐	☐	IDV	☐	☐
FTC	☐	☐	NFV	☐	☐
ABC	☐	☐	LPV/r	☐	☐
DdC	☐	☐	RTV	☐	☐
TDF	☐	☐	(any dose)		
NNRTIs					
NVP	☐	☐	SQV	☐	☐
EFV	☐	☐	DRV	☐	☐
ETV	☐	☐	TPV	☐	☐

OTHER COMMENTS

REFERRED BY

Doctor's name Signature Date