



**NATIONAL HEALTH  
LABORATORY SERVICE**

## **Pathology Request form:**

# **Programme for the Comprehensive Management, Care and Treatment of HIV and AIDS**

# NATIONAL HEALTH LABORATORY SERVICE

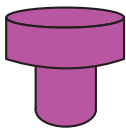

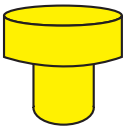
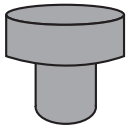
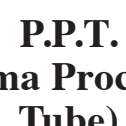
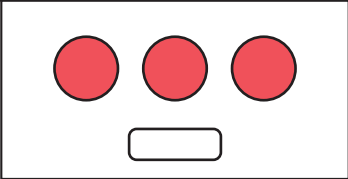
## NHLS Laboratory Results Portals

**Other Prov:** <https://labresults.nhls.ac.za;>

**KZN:** <http://196.7.68.30.8080/trackcarelab/default.htm>

**HOTLINE:** 0860 RESULT (0860 737858)

### Vacutainer - Test tube guide

	Colour	Test Name	Sample volume
 <b>E.D.T.A.</b>	PURPLE / LAVENDER TOP	CD4 count	5ml
		HIV DNA PCR	5ml
		Full blood count	5ml
		HIV VIRAL LOAD	5ml
  OR <b>PLAIN No Additive</b>	RED TOP OR YELLOW TOP	ALT	5ml
		Cholesterol	5ml
		Triglyceride	5ml
		HBsAg ELISA	5ml
		HBsAg Rapid	5ml
		HIV serology	5ml
		HIV rapid	5ml
		Creatinine	5ml
 <b>FLUORIDE / OXLATE</b>	GREY TOP	Glucose	5ml
		Lactate (On ice)	5ml
 <b>P.P.T. (Plasma Processing Tube)</b>	WHITE TOP	HIV viral load	5ml
 <b>DBS (Dried Blood Spot)</b>	RED DRIED BLOOD SPOTS	HIV PCR	Three full spots (circles)

PLEASE TEAR HERE      PLEASE TEAR HERE      PLEASE TEAR HERE      PLEASE TEAR HERE      PLEASE TEAR HERE



**NATIONAL HEALTH LABORATORY SERVICE**

**USE FORM EXCLUSIVELY FOR CCMT CONDITIONAL GRANT TESTING**

KZN <http://196.7.68.30:8080/trakcarelab/default.htm>

HOSPITAL / CLINIC										HEALTH CARE WORKER NAME																													
WARD										SIGNATURE																													
ATTACH PATIENT LABEL HERE PLEASE																				TEL. NO.																			
HOSP/CLINIC NUMBER										FAX NO.																													
SURNAME										HPCSA/SANIC NUMBER																													
FIRST NAMES										ADDRESS																													
ADDRESS																																							
DATE OF BIRTH (DOB)										GENDER					COPIES TO																								
ETHNIC GROUP										COPY TO ADDRESS																													
SPECIMEN TYPE										ACCOUNT TO/PRINCIPAL MEMBER																													
DATE TAKEN										TIME TAKEN					FIN-CLASS					MED AID NAME																			
HEALTH DISTRICT										MED AID NO.										DEP CODE																			
CLINICAL INFORMATION																				MEMBER ADDRESS																			
																				MEMBER TEL (H/W)																			
																				ICD10 CODE(S)																			
COMPREHENSIVE CARE, TREATMENT AND MANAGEMENT (CCTM) PROGRAMME SPECIFIC TESTS																																							
<div><div><input type="checkbox"/> HIV PCR</div><div><input type="checkbox"/> CD4 count</div><div><input type="checkbox"/> ALT</div><div><input type="checkbox"/> FBC</div></div> <div><div><input type="checkbox"/> Cholesterol</div><div><input type="checkbox"/> Triglyceride</div><div><input type="checkbox"/> Glucose</div><div><input type="checkbox"/> HBsAg Rapid</div></div> <div><div><input type="checkbox"/> Lactate (on ice)</div><div><input type="checkbox"/> TB direct (AFB)</div><div><input type="checkbox"/> TB culture</div><div><input type="checkbox"/> HBsAg ELISA</div></div> <div><div><input type="checkbox"/> TB sensitivity</div><div><input type="checkbox"/> Pap Smear</div><div>Result of HIV rapid test done in clinic: _____</div><div><input type="checkbox"/> HIV serology</div></div> <div><div><input type="checkbox"/> Creatinine (est. GFR)</div><div>Please provide:</div><div>Gender <div>f / m</div></div><div>Age <div>yrs.</div></div></div> <div><div><input type="checkbox"/> HIV viral load test:</div><div><input type="checkbox"/> routine monitoring</div><div><input type="checkbox"/> retesting after prior failure</div></div>																																							
THE FOLLOWING DETAILS MUST BE COMPLETED																																							
National ID Number: <div></div>										Current treatment																													
Current HIV Programme Status (please tick only one) :										<div><div><input type="checkbox"/> d4T</div><div><input type="checkbox"/> AZT</div><div><input type="checkbox"/> ddl</div><div><input type="checkbox"/> ABC</div><div><input type="checkbox"/> TDF</div></div> <div><div><input type="checkbox"/> 3TC</div><div><input type="checkbox"/> LPV</div><div><input type="checkbox"/> LPV/r</div><div><input type="checkbox"/> SQV</div><div><input type="checkbox"/> RTV</div></div> <div><div><input type="checkbox"/> EFV</div><div><input type="checkbox"/> NVP</div><div><input type="checkbox"/> Other drugs: _____</div></div> <div><div><input type="checkbox"/> Cotimoxazole</div><div><input type="checkbox"/> INH</div></div> <div><div><input type="checkbox"/> Fluconazole</div><div><input type="checkbox"/> Rif</div></div>																													
PMTCT										PRE-ART																													
PMTCT <input type="checkbox"/> Patient on PMTCT programme										NEW <input type="checkbox"/> Has just enrolled in HIV care, first ever HIV related blood tests																													
BABPM <input type="checkbox"/> Baby exposed to PMTCT										TFI <input type="checkbox"/> Previous CD4 elsewhere, first follow-up here, not yet on ART																													
ART										FU <input type="checkbox"/> Previous CD4 here, testing as part of follow-up care, not yet on ART																													
CARV <input type="checkbox"/> Currently on the antiretrovirals marked										Months since first enrolling on ART at this facility irrespective of stops and restarts: _____																													
PADH <div><div>Y</div><div>N</div></div> Suspected poor adherence																																							
PLEASE NOTE																																							
Please note that this request form must be used in compliance with your provincial treatment guidelines and financial protocols.										<div><div></div><div>AAAA0001P</div></div>										<div>APPLY BAR CODE LENGTHWISE DO NOT WRAP AROUND</div> <div><div><div>✓</div><div></div></div><div><div>✗</div><div></div></div></div>																			
Hotline: 0860 RESULT (737858)																																							
FOR LABORATORY USE ONLY																																							
PROJECT ACCOUNT STAMP					COLLECTED BY					RECEIVED BY																													
Enter Number of Test Tubes Received																																							
PURPLE					YELLOW					PPT																													
DBS CARD					SPUTUM					OTHER																													
GREY					RED																																		
																				Place Laboratory Number barcode Here																			

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