LYMPHOCYTE SURFACE MARKERS (CD4/8 COUNT)

Combined HIV Immunological and Viral Load Request Form

PLEASE INDICATE ALL TESTS REQUIRED

SPECIMEN (Please, complete form using ball point pen)

Date ☐

Time ☐☐ - ☐☐ AM/PM

HIV STATUS

Positive ☐ **Negative** ☐ **Not Known** ☐

PATIENT REFERENCE

Surname ☐

Forename ☐

Gender Male ☐ Female ☐

Soundex ☐

Hospital/Clinic No. ☐

Date of Birth ☐ **CHI No.** ☐

Place of Residence (e.g. EH10-5SB) ☐

TESTS REQUESTED (must be ticked)

☐ **CD4/CD8 COUNT** (Grey and Yellow sheets)

☐ **HIV VIRAL LOAD** (Green and Blue sheets)

COMPLETE AT FIRST ATTENDANCE (Please tick most appropriate statement)

☐ **Newly Diagnosed**

Previously known:

☐ Elsewhere in Scotland

☐ Outwith Scotland (rest of UK)

☐ Outwith UK please specify..

ALL SECTIONS OF THE FORM MUST BE COMPLETED, INCLUDING ALL AREAS RELATING TO PATIENT'S TREATMENT AND CLINICAL DETAILS

1 If VL requested within 3 months of previous test, please tick indication for repeat test

☐ New patient baseline

☐ Patient considering therapy

☐ Recent change in therapy

☐ VL rebound from undetectable

☐ Routine monitoring

☐ Salvage therapy

2 TREATMENT STATUS (Tick one only)

☐ **Naive**

OFF therapy

☐ Stopped within past 3/12

☐ No therapy in past 3/12

ON therapy

☐ Unchanged for past 3/12

☐ Started in past 3/12

☐ Changed in past 3/12

Z 9509158

3 CURRENT ANTIRETROVIRAL THERAPY (Please indicate regimen being taken immediately prior to this appointment)

COMBINATION

☐ Combivir ☐ Kivexa ☐ Truvada ☐ Trizivir ☐ Atripla ☐ Triomune

☐ Other Combination, please state name ....

NUCLEOSIDE ANALOGUES

☐	Abacavir	ABV
☐	Didanosine	ddI
☐	Lamivudine	3TC
☐	Stavudine	D4T
☐	Zalcitabine	ddC
☐	Zidovudine	AZT
☐	Emtricitabine	FTC

NNRTIs

☐ Delavirdine

☐ Efavirenz

☐ Nevirapine

☐ Etravirine

NtRTI

☐ Tenofovir

ENTRY INHIBITORS

☐ Maraviroc

INTEGRASE INHIBITORS

☐ Raltegravir

PROTEASE INHIBITORS

☐ (Fos-) amprenavir

☐ Indinavir

☐ Nelfinavir

☐ Full ☐ Low Ritonavir

☐ Saquinavir

☐ Lopinavir/r (Kaletra)

☐ Atazanavir

☐ Tipranavir

☐ Darunavir

OTHERS

☐ IL-2

☐ T-20

☐ Other*

*Please specify "others"..........

....

....

....

4 HAS THIS PERSON EVER HAD AN AIDS DEFINING ILLNESS?

Yes ☐

No ☐

N/K ☐

5 SIGNIFICANT CLINICAL EVENTS IN PAST 3 MONTHS (Please tick)

☐ No significant events

☐ Minor clinical event, no major clinical event (e.g. oral candida, shingles, pneumonia)

☐ Major clinical event (e.g. PCP, weight loss > 10%, TB, oesophageal candida,MAI, toxoplasma, recurrent pneumonia, KS, CMV, other event previously designated "AIDS defining") ± minor events.

ADDITIONAL INFORMATION

(e.g. change of Soundex of surname, new patient, pregnant)

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....

....

REFERRAL SOURCE

Consultant in charge..

Dr(Capitals)..

Signature..

Address (Clinic/Ward/Hospital/GP) ....

....

....

ID ☐

GUM ☐

Other ☐

GREEN & BLUE COPIES FOR VIRAL LOAD REQUEST.

FOR VIRAL LOAD REQUEST ONLY DESTROY GREY & YELLOW COPIES, DO NOT RE-USE

HIV Viral Load Request Form

Combined HIV Immunological and Viral Load Request Form

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Date

Time - AM/PM

HIV STATUS

Positive ☐ Negative ☐ Not Known ☐

PATIENT REFERENCE

Surname

Forename

Date of Birth | CHI No.

Gender: Male ☐ Female ☐

Soundex

Hospital/Clinic No.

Place of Residence (e.g. EH10-5SB)

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4 ☐ Outwith UK please specify........................

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2 ☐ Patient considering therapy

3 ☐ Recent change in therapy

4 ☐ VL rebound from undetectable

11 ☐ Routine monitoring

13 ☐ Salvage therapy

2 TREATMENT STATUS (Tick one only)

1 ☐ Naive

OFF therapy

5 ☐ Stopped within past 3/12

6 ☐ No therapy in past 3/12

ON therapy

2 ☐ Unchanged for past 3/12

3 ☐ Started in past 3/12

4 ☐ Changed in past 3/12

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☐ Efavirenz

☐ Nevirapine

☐ Etravirine

NtRTI

☐ Tenofovir

ENTRY INHIBITORS

☐ Maraviroc

INTEGRASE INHIBITORS

☐ Raltegravir

PROTEASE INHIBITORS

☐ (Fos-) amprenavir

☐ Indinavir

☐ Nelfinavir

☐ Full ☐ Low Ritonavir

☐ Saquinavir

☐ Lopinavir/r (Kaletra)

☐ Atazanavir

☐ Tipranavir

☐ Darunavir

OTHERS

☐ IL-2

☐ T-20

☐ Other*

*Please specify "others"........................

4 HAS THIS PERSON EVER HAD AN AIDS DEFINING ILLNESS?

VIRAL LOAD	
LOG	
Change from previous	

1 ☐ 2 ☐ 3 ☐

5 SIGNIFICANT CLINICAL EVENTS IN PAST 3 MONTHS (Please tick)

1 ☐ 2 ☐ 3 ☐

Send blue copy with completed result to
HPS
GLASGOW

RETAIN THIS PAGE WITH GREEN COPY FOR VIRAL LOAD

ADDITIONAL INFORMATION

(e.g. change of Soundex of surname, new patient, pregnant)

....

REFERRAL SOURCE

Consultant in charge........................

Dr(Capitals)........................

Signature........................

Address (Clinic/Ward/Hospital/GP)........................

ID ☐ 1
GUM ☐ 2
Other ☐ 3