DATE OF REQUEST VISIT NUMBER:

CHART #: LOCATION:

PATIENT NAME

DATE OF BIRTH MEDICAID ID#

Ordering Physician # _____

Medicaid ID # _____

Attending Physician # _____

☐ **Patient has signed ABN waiver (ABN)**

☐ **Patient refused to sign ABN waiver (ABNR)**

☐ **ABN not required**

BASSETT HEALTHCARE NETWORK

HIV Screening Requisition

LAB TEST REQUEST FORM # 6

8668 7/03;8/03,1/04 ,7/04,9/04,7/05,1/06,4/06,8/2/07, 1/14/08,1/4/10,7/19/2010,3/15/11,1/9/12,1/7/13,4/7/14,5/14/15, 8/4/15,6/9/16,3/13/19,10/20,3,22, 2/26 (f:\lab\.doc)

SPECIMEN COLLECTED BY:	TIME:	DATE:

Please CHECK request below

INSTRUCTIONS: A separate request form must be used for each specimen.

All specimens and request forms must indicate date and time of collection, and note the initials of the person who collected the specimen.

Diagnosis Code:
Descriptive Diagnosis:

PROVIDERS: Compliance is mandatory and regulated. For the laboratory to bill properly and receive payment, you must provide the specific Diagnosis codes for each outpatient test ordered. Additionally, only tests that are medically necessary for the indicated diagnosis or treatment should be ordered, with supporting documentation in the medical record. For tests included in each panel and reflexive testing, please refer to the below. Under current Medicare regulations, when certain laboratory tests (indicated by an *) are ordered, and the diagnosis is not listed in the Local Coverage Determination or National Coverage Determination for that test, payment may be denied. In these cases Medicare requires an Advance Beneficiary Notice (waiver of liability) be signed to allow the hospital to bill the patient. The ABN box on the requisition MUST be checked when an ABN is obtained.

☐ LAB473 HIV type-1/0/2 Antibody and Antigen Screen ☐ Routine ☐ STAT

Specimen: Venipuncture (Use Lavender Top only)
Preliminary positive results will be released
Positive results will reflex to confirmatory testing.

☐ LAB4730 Pediatric HIV

Specimen: Venipuncture (Use Lavender Top only)

For high-risk infants, collect blood at 8-12 weeks (in addition to the collections within 48 hours of birth, 2 weeks, 4-6 weeks, and 4-6 months of age).

REFLEXIVE TESTING

1. NYSDOH requires all positive HIV Antibody screening tests to be confirmed by Multispot Antibody Differentiation. These are referred to a reference laboratory and there will be additional charges for this testing.
2. Positive HIV Antigen screening test will be confirmed by nucleic acid testing.

Provider's Signature: _____

Signed Date and Time: _____

Received by: _____