COLUMBIA HEALTH
Medical Services

John Jay Hall
519 W 114th Street
Mail Code 3601
New York, NY 10027
Phone 212.854.7426
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HIV1/2 ANTIBODY/ANTIGEN TEST REQUEST

Deleted: 2284

Patient Information

Last Name: _____ DOB-mm/dd/yyyy: ____/_____/_____

First Name: _____

Immunization or viral illnesses in last 3 mos?

No / Yes_____

Lab Order

❒ **Alere Determine HIV-1/2 Ag/Ab Combo Test (Fingerstick Whole Blood)** – *special request*

❒ **HIV-1/0/2 Antigen/Antibody, 4th Generation (LabCorp #083935) –** *default test*

❒ **RPR (Rapid Plasma Reagin) – *requires student insurance*** (or acceptance of possible charges)

SUBMITTER ATTESTATION STATEMENT	
I certify that the patient has received information about limitations, risks, and the voluntary nature of the test and has received pre-test counseling.	
Physician Richard O'Keefe, M.D. NYS LIC # 175642 Diagnosis (ICD-10): Z11.3	Signature

Advocate _____ **Date** _____

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