A DEDICATED TUBE IS REQUIRED FOR HIV TEST REQUESTS

LABORATORY ALLIANCE
of Central New York, LLC
113 Innovation Lane • Liverpool, New York 13088
Ph: (315) 461-3008 Fax: (315) 461-3090

PLACE BAR CODE LABEL HERE

VO BOX

SPECIMEN INFORMATION

DATE COLLECTED	TIME COLLECTED ❑ AM ❑ PM
COLLECTED BY	
COPY TO ______	

PHYSICIAN'S SIGNATURE REQUIRED

______

PATIENT INFORMATION

PATIENT NAME (LAST/FIRST/MI)		PATIENT I.D. NO.
SOCIAL SECURITY NO.	DATE OF BIRTH	SEX ❑ MALE ❑ FEMALE
STREET ADDRESS		
CITY, STATE, ZIP		PHONE NO.

INSURANCE BILLING INFORMATION

RESPONSIBLE PARTY (SUBSCRIBER)	SUBSCRIBER'S SOCIAL SECURITY NO.
SUBSCRIBER'S STREET ADDRESS	
SUBSCRIBER'S CITY, STATE, ZIP	PATIENT RELATIONSHIP TO INSURED ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER ______
EMPLOYER NAME & ADDRESS	
PRIMARY INSURANCE: CO. NAME	POLICY NO.
SECONDARY INSURANCE: CO. NAME	POLICY NO.

ICD9 DIAGNOSIS CODE(S) FOR TESTS ORDERED *(MUST BE PROVIDED)*

DIAGNOSTIC TESTS

HIV12 ❑ **HIV 1+2 ANTIBODY***

HIVP ❑ **HIV-1 ANTIBODY EIA WITH PRELIMINARY RESULTS***
(FOR ED, L&D AND EMPLOYEE EXPOSURE ONLY).
❑ **CHECK IF SPECIMEN IS CORD BLOOD**

** All positive results will be referred to reference lab for confirmatory testing.*

*** For additional HIV testing please use Laboratory Alliance General Testing Requisition.*

LAC705 REV 12/10