"POSITIVE HIV DETECTION" REPORTING FORM

PRIMARY/INDEX LAB'S NAME: _____ **ADDRESS:** _____

City *State* *Zip*

PHONE: ( ) _____ - _____ **CLIA ID#** _____ **DATE SENT (mm/dd/yyyy):** ____/____/_____ **BY**_____

LAST NAME		FIRST NAME		MIDDLE NAME	PROVIDER'S CONTACT INFORMATION
DATE OF BIRTH (mm/dd/yyyy)	GENDER(1-4)	ACCESSION NUMBER	DATE TESTED (mm/dd/yyyy)	DATE DRAWN (mm/dd/yyyy)	Address
					City State Zip Phone CA ( )
TESTERFORMED ("X" ROPRIATE)	☐ CULTURE	☐ ANTIGEN	☐ PCR/DNA/RNA PROBE	☐ OTHER	MD's Name Phone ( )

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Mail to: County of Los Angeles
Department of Health Services
600 S. Commonwealth Ave, Suite #1260
Los Angeles, CA 90005-4001
Help Desk: 213-487-8516

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