HIV RAPID TEST REQUISITION (Occupational Exposures Only)

Albany Medical Center

(Requisition will be returned prior to testing if incomplete)

DATE COLLECTED	TIME COLLECTED	PHLEBOTOMIST INITIALS:	**AFFIX SOURCE PT ARRIVAL LABEL OR COMPLETE BELOW:** **Source PT NAME:(Last, First)**
DATE RECEIVED	TIME RECEIVED	TECH INITIALS:	**MR#:** ______ **DOB:** ______ **SEX:** ______

☐ **Anonymous Source (See Anonymous Testing Only, Shaded Area Below).**

REQUIRED EXPOSED INFORMATION

✱ALL FIELDS MUST BE COMPLETED TO PROCESS REQUEST ✱

☐ **NON-AMC Employee** (Complete Exposed Employer Company Information Section) ☐ **AMC Employee** ______ (EHS Account#)

Name of Exposed: ______ Date of Birth of Exposed: ______

Exposed's Occupation: (The occpation that was performed when exposure occurred)

☐ Health Care Worker ☐ EMT ☐ Fire/rescue personnel ☐ Police Officer ☐ Good Samaritan ☐ Other ______

Exposed Employeer Company information (REQUIRED FOR NON-AMC EMPLOYEE)

Company Name ______

Company Address ______

Company phone number ______ Contact Person ______

Date of Injury ___/___/___

FOR ANONYMOUS TESTING ONLY

All source patients must be advised before an HIV-related test is performed, and no test may be administered over his or her objection. If the patient objects to the HIV test, such objection must be documented in the medical record. If the patient lacks actual capacity, consent must be obtained from the health care agent, guardian or surrogate. If patients lack capacity to make their own decisions, and have not executed a Health Care Proxy,the Family Health Care Decisions Act (FHCDA) specifies using a prioritized surrogate list by which to determine who, if anyone, has legal authority to make health care decisions.

Advising that an HIV-related test from a source patient is being performed is not required in following limited circumstances. If the patient cannot consent and all three criteria are met then Anonymous testing for HIV is to be performed on the Source patient according to the chapter 308 laws of 2010. Please initial and check all criteria, if all three criteria are met and an ANONYMOUS RAPID HIV IS BEING DRAWN. Check the Anonymous Source box for the source patient info. DO NOT AFFIX SOURCE PATIENT LABEL.

______ Initial ☐ 1. The source is deceased, comatose or is determined by his/her Attending Physician to lack mental capacity to consent to HIV testing and is not reasonably expected to recover in time for the exposed person to receive appropriate medical treatment **AND**

______ Initial ☐ 2. There is no person reasonably available or likely to become available with the legal authority to consent to the HIV test on behalf of the source patient in time for the exposed person to receive medically appropriate treatment; **AND**

______ Initial ☐ 3. The exposed person will benefit medically by knowing the source patient's HIV test results, as determined by the exposed person's health care professional and documented in the exposed person's medical record.

If the following criteria are not met consider advising the patient HIV-related testing is being performed or contact HIV Medicine for assistance at (518) 262-4043

NOTIFICATION TO PHYSICIANS AND OTHER PERSONS LEGALLY AUTHORIZED TO ORDER TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT: MEDICARE WILL ONLY PAY FOR TESTS THAT MEET THE MEDICARE COVERAGE CRITERIA AND ARE REASONABLE AND NECESSARY TO TREAT OR DIAGNOSE AN INDIVIDUAL PATIENT. MEDICARE DOES NOT PAY FOR TESTS FOR WHICH DOCUMENTATION, INCLUDING THE MEDICAL RECORD, DOES NOT SUPPORT THAT THE TESTS WERE REASONABLE AND NECESSARY. MEDICARE GENERALLY DOES NOT COVER ROUTINE SCREENING TESTS EVEN IF THE PHYSICIAN OR OTHER AUTHORIZED PRACTITIONER CONSIDERS THE TESTS APPROPRIATE FOR THE PATIENT.

Test Ordering Information:

☒ HIV Antigen/Antibody Combo
(Draw two 3 ml Red or Gold top tube)

Confirmatory/Reflex testing will be performed at an additional charge under the following circumstances:
All positive/reactive samples will be confirmed by HIV Antibody Differentiation Assay. If the HIV Antibody Differentiation is negative or indeterminate, nucleic acid testing will be performed.

Medicare limited coverage policy, ABN may be required.

Ordering Physician: ______

☐ Request Preliminary Report
Call to: (If Preliminary Report is requested.)

☐ Occ Med ☐ Urgent Care Name: ______

Admin. Supervisor: ______

Fax# ______ Phone# ______ Beep# ______

(IF EXPOSED IS AMC EMPLOYEE FAX COPY OF PRELIMIARY REPORT TO EHS X23873)

Signature of Person Authorized to Order HIV Related Test:

Please note that patients must be advised that HIV-related testing is being performed per NYS law and CDC recommendations. In the event of Anonymous testing for HIV, this signature attests that all of the above criteria were met.

Time of Order: ______

Physician Signature: ______ License #: ______
(Physician or other person authorized to order an HIV related test)

Print Name: ______

Attending/HIV Counselor Name: ______

DIAGNOSIS / ICD10 CODES Mandatory for each test ordered
BBP EXPOSURE Source Patient

Lab Use Only:

Billing Code:	Acc#	Specimen ID #:
Billing MRN:	Billing Account #	

43 New Scotland Ave, Albany, NY 12208 Albany Medical Center Department of Serology/Immunology PH: (518)262-3508, Fax: (518)262-8120