DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Please Note: ALL FIELDS ARE REQUIRED for Sections 1-4. Then proceed to Section 5 for Reporting Information. Please print legibly.

Lab Slip

Section 1: Organization Information			
Organization Name:			
Street Address:			
City:	State: DE	Zip Code:	Phone Number:
Evaluation Web Form ID:			Fax Number:

Section 2: Client Information			
Client Name:			
Client Street Address:			
Client City:		State:	Zip Code:
Client DOB:	SSN:		Client Phone:
Sex at birth: ☐Female ☐ Male ☐Declined to Answer	Gender Identify: ☐Female ☐ Male ☐ Transgender – FTM ☐Transgender – MTF ☐ Transgender – Unspecified ☐ Another Gender ☐ Declined to Answer		
Race: ☐ African American ☐ Caucasian ☐ Asian ☐ American Indian/Alaskan Native ☐ Don't Know ☐ Declined	Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Don't Know ☐ Declined	Risk: (check all that apply) ☐ Sex with Male ☐ Sex with Female ☐ Injected Drugs	

Section 3: Testing			
Name of Tester	Type of Test	Result	Date of Test
	☐SURECHECK ☐ORAQUICK	☐ Reactive	
Signature of Tester:			
Previous Positive?	☐Yes ☐No		

Section 4: Referral/Linkage to Care

***If reactive and not previously positive make appointment for confirmatory testing. Once results are received from DPHL (3-5 business days), link client to HIV care appointment.*

Refused Confirmatory Testing:	☐ Yes ☐ No
Was an appointment made for confirmation testing? ☐ Yes ☐ No	If yes, please indicate which State Service Center and date/time of appointment: ☐ Porter ☐ Adams/Georgetown ☐ Shipley ☐ Williams ☐ Milford ☐ Pyle ☐ Hudson Appointment Date: __/__/____ Time: ___:___ AM/PM

Section 5: Reporting

For all reactive results, HIV surveillance **MUST** be notified via phone. Please contact the Surveillance Office at the following phone numbers: (Call in order shown)

302-744-1005 / 302-744-1015 / 302-744-1004 / 302-744-1006 / 302-744-1226

Once this form is completed, it **MUST** be faxed to the attention of HIV Surveillance/Prevention at:

302-739-2550

SECTION 6: HIV PREVENTION/SURVEILLANCE PROGRAM STAFF USE ONLY		
City Code:	Stateno:	Care Status:
Case Number:	Person ID:	
Case Assignment & Date:		