Version 3: 05/2026
AV-C_EN

REQUEST FORM HIV DIAGNOSTIC CONFIRMATION TEST

AIDS REFERENCE LABORATORY

UMC St Pieter	**CHU St Pierre**
Hoogstraat 322	Rue Haute 322
1000 Brussel	1000 Bruxelles
Tel: 02/435 20 61	Fax: 02/435 20 69

Sample identification
(Reserved for ARL)

Each positive HIV screen test (≥4th generation should be used) needs to be further analysed by an AIDS Reference Laboratory with specialized tests to confirm a possible HIV diagnosis.

PATIENT INFORMATION

INSZ/NISS Code:

Name:

First name:

Date of birth:

Gender:

Address:

Antiretroviral therapy at collection date:

☐ Unknown

☐ No treatment

☐ Treatment (PREP, PEP,…provide details)

Country of origin (useful for subtype HIV)**:**

SAMPLE INFORMATION* (preferably at least 1ml)

Sample ID:

Collection date and time:

Type of sample: ☐ serum ☐ plasma

Without anticoagulentium; lithium heparin or EDTA
☐ OK
☐ NOK specify :

Storage of sample:

max 3 days at 2°- 8°C,
otherwise -20 or -80°C. Avoid repetitive freeze-thawing.
☐ OK
☐ NOK specify :

Screening test(s)

- **Name test kit used:**
- **Manufacturer:**
- **Cut-off kit used:**
- **Test result (value)**
  - **Ag:**
  - **Ab:**

REQUESTER INFORMATION

Laboratory:

Contact person in laboratory (name and tel)**:**

Clinician requesting analysis (name + RIZIV/INAMI nr! + Address)**:**

*Sample should arrive at the AIDS Reference Laboratory at the latest at 16h, from Monday to Friday. Cooled transport
For any questions or complaints please contact the laboratory at 02/435 20 61