Laboratory Investigation Form (Request and Results)	Date: _____ / _____ / _____ DD MM YY	Time of collection: ___: ___ HH MM
Name:		Site:
Patient ID:	Date of Birth: _____ / ____ / _____ DD MM YYYY	Age:
Visit type: O Enrollment O Follow-up O Other visit type	Last CD4: _____ CD4 Date: _____/____/_____ DD MM YYYY HAART: O Yes O No	Sex: O Male O Female

Relevant Clinical Findings:

Heamatology	**Results**	**Serology**	**Results**	**Microbiology**	**Results**
Hb		SCrag		Urinalysis	
CD4		Widal		Proteins	
CD4%		HIV Rapid Test(s)		Glucose	
				Leucocytes	
Haemogram (Total WBC count)		RPR	O Positive O Negative	M/S	O Positive O Negative

Chemistry	**Results**		**Results**	**Radiology**	**Results**
Creatinine		Lipid Profile		CXR	
ALT		Total Cholesterol			
PDT		HDL			
		LDL			
		Triglicerides		Other: _____	

Other/Lab CXR	**Results/Comments**
Other (specify):	

Requested by Clinician Nurse

Provider Name: _____ Initials: _____

Lab Tech Name: _____ Initials: _____

Lab Comments: