

PATIENT'S ADDRESS		NAME PT SEX (M)	
Suburb/Town	Postcode	Date of Birth	REPATRIATION PATIENT REPAT. NO.
Requesting doctor's name and full return address (for report)			
Dr. S. Helling DIV. OF FORENSIC MEDICINE 4250 PARADISE DR. CROFTON			
PHONE NO.	Name of Medical Practitioner	Provider No.	Signature of Medical Practitioner
04-5772	HOLLINGER	24301W	<i>[Signature]</i>
Date			
14/12/88			
Was or will the patient be, at the time of the service or when the specimen is obtained a) a private patient in a private hospital, or approved day hospital facility. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> b) a private patient in a recognised hospital. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> c) a hospital patient in a recognised hospital. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d) an outpatient of a recognised hospital. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
Tests Requested (in requesting doctor's own handwriting):			
Anti-HIV			

Date of despatch	VIROLOGY DEPARTMENT REPORT	Serial Number
	Phone Number 633 7753	88-V-

F 15-12-88

Antibody to HIV1 (HTLVIII) NEGATIVE:

This result does not exclude infection with HIV virus. If serum was taken less than three months after exposure please retest after this time.

BB
 Dr. A. Cunningham
 Medical Virologist

MR-59(D) Micro 58

Chief Virologist.