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| Nazwa i adres laboratorium1) | **ZLB-3**  **Zgłoszenie dodatniego wyniku badania w kierunku ludzkiego wirusa niedoboru odporności (HIV)** | Adresaci:  **Państwowy Powiatowy Inspektor Sanitarny**  **w** ........................................................................ |
| **Resortowy kod identyfikacyjny podmiotu leczniczego**2)  Część I. Numer księgi rejestrowej   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |   Część II. TERYT siedziby   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |   Część VII. Komórka organizacyjna   |  |  |  | | --- | --- | --- | |  |  |  | | **Uwagi:**  1) W przypadku dokumentu sporządzonego w postaci papierowej dane mogą być naniesione na dokument w formie pieczątki albo nadruku.  2) Wypełnić zgodnie z rozporządzeniem Ministra Zdrowia z dnia 17 maja 2012 r. w sprawie systemu resortowych kodów identyfikacyjnych oraz szczegółowego sposobu ich nadawania (Dz. U. z 2019 r. poz. 173).  3) W przypadku zastrzeżenia danych przez osobę, u której stwierdzono dodatni wynik badania w kierunku ludzkiego wirusa niedoboru odporności (HIV), należy wypełnić wyłącznie pola: Nazwisko i Imię – wpisując INICJAŁY nazwiska i imienia lub pole HASŁO, Wiek i Płeć, a w polu Miejscowość – nazwę powiatu właściwego ze względu na miejsce zamieszkania.  4) Wypełnić w przypadku, gdy osobie nie nadano numeru PESEL, wpisując serię i numer paszportu albo nazwę i numer identyfikacyjny innego dokumentu, na podstawie którego jest możliwe ustalenie danych osobowych. | |
| **I. WYNIK BADANIA**  1. Data uzyskania wyniku (dd/mm/rrrr)   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | / |  |  | / |  |  |  |  |     2. Typ wirusa   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | HIV-1 |  |  |  | HIV-2 |  |  | |  |  |  |  |  |  |  |  |   3. Numer badania: ……………………………………………………………………………………………………………………………………  4. Metoda diagnostyczna:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | western-blot |  | badanie wirusologiczne |  | badanie molekularne |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | badanie immunoenzymatyczne EIA |  | inna (wpisać jaka)……………………………………………………………………… |  |  | | | |
| **II. Dane osoby, u której stwierdzono dodatni wynik badania w kierunku LUDZKIEGO WIRUSA NIEDOBORU ODPORNOŚCI (hiv)**3)  1. Nazwisko/INICJAŁ3)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   2. Imię/INICJAŁ3) 3. Data urodzenia (dd/mm/rrrr) 4. Numer PESEL   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | / |  |  | / |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   5. Nazwa i numer identyfikacyjny dokumentu4) 6. Płeć (M, K)3) 7. Wiek3) 8. Hasło   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   9. Obywatelstwo   |  | | --- | |  |   Adres miejsca zamieszkania:  10. Kod pocztowy 11. Miejscowość3)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | – |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   12. Województwo 13. Powiat 14. Gmina   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   15. Ulica 16. Numer domu 17. Numer lokalu     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   18.   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | Brak danych w zakresie pkt 1–17 |  |  |  |  |  |  | | | |
| **III. DANE PODMIOTU LECZNICZEGO LUB OSOBY ZLECAJĄCEJ BADANIE:**  1. Nazwisko (lub nazwa podmiotu leczniczego)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   2. Imię (lub nazwa podmiotu leczniczego) 3. Numer prawa wykonywania zawodu   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   4. Nazwa komórki organizacyjnej zakładu leczniczego albo praktyki lekarskiej, w których wystawiono zlecenie lekarskie:  …………………………………………………………………………………………………………………………………………………………………….  5. Numer telefonu   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |   6. Kod pocztowy 7. Miejscowość   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | – |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   8. Ulica 9. Numer domu 10. Numer lokalu   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | | |
| **IV. inne informacje**  1. Data pobrania próbki (dd/mm/rrrr)   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | / |  |  | / |  |  |  |  |   2. Powód wykonania badania:   |  |  | | --- | --- | |  | diagnostyka kliniczna w kierunku HIV/AIDS pacjenta leczonego ambulatoryjnie |  |  |  | | --- | --- | |  | diagnostyka kliniczna w kierunku HIV/AIDS pacjenta hospitalizowanego |  |  |  | | --- | --- | |  | diagnostyka kliniczna w kierunku zakażenia wertykalnego HIV/AIDS |   2a. Badanie przesiewowe:   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | przyjęcie do szpitala |  | kobiety ciężarne |  | pracownicze badania okresowe |  |  | |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | z ośrodków leczenia uzależnień |  |  |  | osób osadzonych w więzieniach/aresztach |  |  | |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | |  | pacjentów poradni chorób przenoszonych drogą płciową  ............................................................................................................................................................. |     2b. Badanie z inicjatywy osoby badanej:   |  |  | | --- | --- | |  | klient Punktu Konsultacyjno-Diagnostycznego (PKD) 🡪 Nr ankiety PKD ………………………. |  |  |  | | --- | --- | |  | bez zlecenia lekarskiego |   2c. Inny powód (jaki):………………………………………………………………………………………… | | |
| **V. Dane OSOBY zgłaszająceJ** (wpisać albo nanieść nadrukiem albo pieczątką)  1. Imię i nazwisko ............................................................... 2. Numer prawa wykonywania zawodu: ...........................………. 3. Podpis ............................  4. Telefon kontaktowy: ....................................................... 5. E-mail: ....................................................... | | |