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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

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Część II. TERYT siedziby

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Część VII. Komórka organizacyjna

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 | **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)

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 2. Typ wirusa

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|  |  HIV-1 |  |   |  | HIV-2 |  |  |
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3. Numer badania: …………………………………………………………………………………………………………………………………… 4. Metoda diagnostyczna:

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|  |  western-blot  |  |  badanie wirusologiczne |  |  badanie molekularne   |

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|  |  badanie immunoenzymatyczne EIA  |  |  inna (wpisać jaka)……………………………………………………………………… |  |    |

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| **II. Dane osoby, u której stwierdzono dodatni wynik badania w kierunku LUDZKIEGO WIRUSA NIEDOBORU ODPORNOŚCI (hiv)**3)1. Nazwisko/INICJAŁ3)

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2. Imię/INICJAŁ3) 3. Data urodzenia (dd/mm/rrrr) 4. Numer PESEL

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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5. Nazwa i numer identyfikacyjny dokumentu4) 6. Płeć (M, K)3) 7. Wiek3) 8. Hasło

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9. Obywatelstwo

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Adres miejsca zamieszkania:10. Kod pocztowy 11. Miejscowość3)

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12. Województwo 13. Powiat 14. Gmina

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15. Ulica 16. Numer domu 17. Numer lokalu

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18.

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|  |  Brak danych w zakresie pkt 1–17 |  |   |  |  |  |  |

 |
| **III. DANE PODMIOTU LECZNICZEGO LUB OSOBY ZLECAJĄCEJ BADANIE:** 1. Nazwisko (lub nazwa podmiotu leczniczego)

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2. Imię (lub nazwa podmiotu leczniczego) 3. Numer prawa wykonywania zawodu

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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4. Nazwa komórki organizacyjnej zakładu leczniczego albo praktyki lekarskiej, w których wystawiono zlecenie lekarskie:…………………………………………………………………………………………………………………………………………………………………….5. Numer telefonu

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6. Kod pocztowy 7. Miejscowość

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8. Ulica 9. Numer domu 10. Numer lokalu

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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 |
| **IV. inne informacje** 1. Data pobrania próbki (dd/mm/rrrr)

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2. Powód wykonania badania:

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| --- | --- |
|  | 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:

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|  |  przyjęcie do szpitala |  |  kobiety ciężarne |  | pracownicze badania okresowe |  |  |
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|  |  z ośrodków leczenia uzależnień |  |   |  | osób osadzonych w więzieniach/aresztach |  |  |
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|  |  pacjentów poradni chorób przenoszonych drogą płciową............................................................................................................................................................. |

 2b. Badanie z inicjatywy osoby badanej:

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|  | klient Punktu Konsultacyjno-Diagnostycznego (PKD) 🡪 Nr ankiety PKD ………………………. |

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| --- | --- |
|  | 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: ....................................................... |