WOMEN'S INTERAGENCY HIV STUDY

BLOOD SPECIMEN COLLECTION FORM

FORM 29

ID LABEL HERE ---> |__| - |__|__| - |__|__|__|__| - |__|

VISIT #: ___ ___

FORM COMPLETED BY: ___ ___ ___

VERSION DATE REVISED **03/01/96**

ANY MISSING OR INCOMPLETE TEST RESULTS MUST BE EXPLAINED ON THIS FORM.

SECTION A.

IF BLOOD DRAW OCCURS AT TWO DIFFERENT TIMES AND/OR DATES FOR THIS VISIT, COMPLETE THE INFORMATION REQUESTED IN A1 - A11, THEN INDICATE TOTAL NUMBER OF TUBES COLLECTED DURING BOTH BLOOD DRAWS IN SECTION B. IF ONLY ONE BLOOD DRAW OCCURRED, COMPLETE A1 - A6 AND PROCEED TO SECTION B.

A1. DATE BLOOD DRAWN: ___ ___ / ___ ___ / ___ ___
(M / D / Y)

A2. TIME BLOOD DRAWN: |___|___| : |___|___|
AM 1
PM 2

A3. PHLEBOTOMIST'S INITIALS ___ ___ ___

A4. WERE CPT TUBES CENTRIFUGED IN CLINIC; (i.e. PRIOR TO SENDING TO LAB FOR PROCESSING)

YES 1
NO.. 2 **(A6)**
N/A (Not drawn this date).......................... 3 **(A6)**

A5. TIME CPT TUBES CENTRIFUGED: |___|___| : |___|___|
AM 1
PM 2

A6. WAS BLOOD DRAWN ON A SECOND DATE FOR THIS VISIT?

YES 1
NO.. 2 **(B1)**

A7. DATE OF SECOND BLOOD DRAW: ___ ___ / ___ ___ / ___ ___
(M / D / Y)

A8. TIME OF SECOND BLOOD DRAW: |___|___| : |___|___|
AM 1
PM 2

A9. PHLEBOTOMIST'S INITIALS ___ ___ ___

A10. WERE CPT TUBES CENTRIFUGED IN CLINIC; (i.e. PRIOR TO SENDING TO LAB FOR PROCESSING)

YES 1
NO.. 2 **(B1)**
N/A (Not drawn this date).......................... 3 **(B1)**

A11. TIME CPT TUBES CENTRIFUGED: |___|___| : |___|___|
AM 1
PM 2

WIHS ID #

SECTION B. BLOOD DRAW

LISTED IN ORDER OF PRIORITY

	TEST TYPE	TUBE TYPE	VOLUME	a.) SPECIMEN COLLECTED			b.) REQUIRED VOLUME COLLECTED		c.) ESTIMATED VOLUME COLLECTED
				YES	NO	N/A	YES	NO	
B1.	HIV Ab	Red-Top	1-2 ml	1	2	3*	1 (B2)	2	|__|__| mls.
		IF NO SPECIFY REASON		i. __________________					
B2.	CBC/Diff	Purple-Top	2-5 ml	1	2		1 (B3)	2	|__|__| mls.
		IF NO SPECIFY REASON		i. __________________					
B3.	T-Cell Subsets	Purple-Top	2-5 ml	1	2		1 (B4)	2	|__|__| mls.
		IF NO SPECIFY REASON		i. __________________					
B4.	Plasma & Cells Repository **	CPT Tube	8 ml	1	2		1 (B5)	2	|__|__| mls.
		IF NO SPECIFY REASON		i. __________________					
B5.	Plasma & Cell Repository	CPT Tube	8 ml	1	2		1 (B6)	2	|__|__| mls.
		IF NO SPECIFY REASON		i. __________________					
B6.	Plasma & Cell Repository	CPT Tube	8 ml	1	2		1 (B7)	2	|__|__| mls.
		IF NO SPECIFY REASON		i. __________________					
B7.	Plasma & Cell Repository	CPT Tube	8 ml	1	2		1 (B8)	2	|__|__| mls.
		IF NO SPECIFY REASON		i. __________________					
B8.	Plasma & Cell Repository	CPT Tube	8 ml	1	2		1 (B9)	2	|__|__| mls.
		IF NO SPECIFY REASON		i. __________________					
B9.	Liver/Renal Function	Red-Top	2-5 ml	1	2	3***	1 (B10)	2	|__|__| mls.
		IF NO SPECIFY REASON		i. __________________					
B10.	RPR Syphilis	Red-Top	2-5 ml	1	2	3****	1 (B11)	2	|__|__| mls.
		IF NO SPECIFY REASON		i. __________________					
B11.	Serum Repository	Red-Top	10 ml	1	2		1 **(END)**	2	|__|__| mls.
		IF NO SPECIFY REASON		i. __________________					

* Not required after visit one on HIV positive women
** Includes plasma to be used for viral quantification by RNA PCR
*** Collect annually on odd visits only (Visit 1, Visit 3, Visit 5, etc..)
****Collect annually on even visits only (Visit 4, Visit 6, etc..)