

**WOMEN'S INTERAGENCY HIV STUDY**  
**BLOOD SPECIMEN COLLECTION FORM**  
**FORM 29**

ID LABEL HERE ---> |\_| - |\_|\_| - |\_|\_|\_|\_| - |\_|

VISIT #: \_\_\_\_\_ FORM COMPLETED BY: \_\_\_\_\_

VERSION DATE REVISED **04/01/01**

**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

**SECTION B. BLOOD DRAW (LISTED IN ORDER OF PRIORITY)**

	<u>TEST TYPE</u>	<u>TUBE TYPE</u>	<u>VOLUME</u>	<u>a.) SPECIMEN COLLECTED</u>			<u>b.)REQUIRED VOLUME COLLECTED</u>		<u>c.) ESTIMATED VOLUME COLLECTED</u>
				<u>YES</u>	<u>NO</u>	<u>N/A</u>	<u>YES</u>	<u>NO</u>	
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	3***	1 (B3)	2	___ ___  mls.
		IF NO SPECIFY REASON		i. _____					
B3.	T-Cell Subsets	Purple-Top	2-5 ml	1	2	3***	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		1 (B10)	2	___ ___  mls.
		IF NO SPECIFY REASON		i. _____					
B10.	Insulin/Lipids Repository ****	Tiger-top SST	5 ml	1	2		1 (B11)	2	___ ___  mls.
		IF NO SPECIFY REASON		i. _____					

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	<u>TEST TYPE</u>	<u>TUBE TYPE</u>	<u>VOLUME</u>	<u>a.) SPECIMEN COLLECTED</u>			<u>b.) REQUIRED VOLUME COLLECTED</u>		<u>c.) ESTIMATED VOLUME COLLECTED</u>
				<u>YES</u>	<u>NO</u>	<u>N/A</u>	<u>YES</u>	<u>NO</u>	
B11.	Hemoglobin A1c Repository ****	Purple-Top (pediatric) IF NO SPECIFY REASON	2.5 ml	1	2		1 (B12)	2	mls.
B12.	Glucose Repository ****	Gray-Top (3 ml size) IF NO SPECIFY REASON	3 ml	1	2		1 (B13)	2	mls.
B13.	Serum Repository	Red-Top IF NO SPECIFY REASON	10 ml	1	2		1 (END)	2	mls.

- \* Not required after visit one on HIV positive women
- \*\* Includes plasma to be used for viral quantification by RNA PCR
- \*\*\* For HIV-seronegative participants, collect annually on even visits only
- \*\*\*\* Collect on all participants, whether or not fasting.