

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

ID LABEL HERE --->

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

VERSION DATE REVISED **08/01/95**

**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	<u>YES</u> 1	<u>NO</u> 2	<u>N/A</u> 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.	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..)