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

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	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. _____					

WIHS ID #

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