

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		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..)