TB Clinic Instructions for Collection, Submission Form and Mailing

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The Office of Laboratory Services provides the following testing supplies:

1. 8.5mL SST blood tubes (gray and red top tubes)
2. Eclipse needle hub assembly
3. A copy of the Diagnostic Immunology ***Outbreak submission form***.
    - Facilities can fill in the submitter data and then make copies for use.

Blood Specimen Collecting Instructions:

1. Collect venous blood into clean SST tubes filling approximately 2/3 full, following your facility's proper phlebotomy procedures.
2. It is <u>best practice</u> to provide one well filled blood tube for each test type being requested **(1 for Hepatitis B, 1 for Hepatitis C and 1 for HIV).** However, if not possible two blood tubes are acceptable.
3. At a minimum, place patient's first and last name and draw date on the collection tube. The use of pre-printed labels is acceptable (the information on the tube and form must match exactly).
4. <u>Best Practice</u> is to gently invert the tubes after collection and allow the specimen to clot (30 minutes) and then centrifuge at 2800 RPMs for a minimum of 10 minutes.
5. Allowing the serum to sit on the clot for long periods can cause hemolysis. Badly hemolyzed, very lipemic or bacterially contaminated blood produces unreliable results.
6. Package and send specimens to the lab immediately after collection, to insure best results.
7. ***If your facility is unable to centrifuge the samples, contact the lab for more information*.**

Form Instructions:

Please print legibly.

1. The Clinical Laboratory Improvement Amendments (CLIA) requires:
    a. **A unique identifier on both the form and the specimen (usually first and last name)**
    b. **Address of Submitter**
    c. **Date of Birth or Age of Patient**
    d. **Gender of Patient**
    e. **The Test to be Performed**
    f. **The Source of the Specimen- Blood/Serum**
    g. **Date of Collection**
    h. **Any Additional Information relevant to testing (i.e. information necessary by the program)**

2. The instructions indicate if the information is Optional, CLIA required or Program required.

PATIENT INFORMATION

PATIENT ID (Chart #, etc.) *(optional)*		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	SS# (last 4 digits only)	
COUNTY OF RESIDENCE	SEX (at birth) ❑ Female ❑ Male	
STREET ADDRESS		
CITY	STATE	ZIP
PATIENT PHONE NO.(include area code)		
RACE ❑ White ❑ Asian ❑ Black ❑ Other ❑ American Indian/Alaskan ❑ Native Hawaiian or other Pacific Islander	ETHNICITY ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑Unknown	
PATIENT TYPE (for Hepatitis Testing only): ❑ Employee ☒ Patient ❑ Investigation		

Patient Information:

a. **Patient ID** – This refers to a chart number or some other internal ID that your facility uses to identify patients. A maximum of 15 characters is allowed *(Optional).*
b. **Last Name, First Name, MI** – Patients full name. (*Unique identifier required by CLIA. Information on tube and form should match).*
c. **Date of Birth** – *(Required by CLIA).*
d. **Social Security Number** – last 4 digits only **(***Optional).*
e. **County of Residence** – The patient's county of residence is not always the same as the provider's county. *(Required by Program)*
f. **Sex** – **(***Required by CLIA)*
g. **Street Address, City, State, Zip Code**- *(Required by program)*
h. **Patient Phone Number- include area code** *(Required by program)*
i. **Race** – More than one can be marked *(Required by program)*
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j. **Ethnicity** – (*Required by* program)
k. **Patient Type – (***this field is pre-marked on TB Clinic form).*

Submitter Information:

a. **Facility Name** – The official name of the site as listed on the MOU. **Do not use the initials of your site.** *(Required by CLIA)*
b. **Street Address, City, State, Zip Code**- **(***Required by CLIA)*
c. **County**- (*Required by Program)*
d. **Attention To**: - This line is to be filled out if the results are to go to a specific individual or department within the facility. *(Optional)*
e. **Phone Number and Fax Number – include area code (***Required by Program)*

SUBMITTER INFORMATION

FACILITY NAME:		
MAILING ADDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO:		
PHONE NO. (include area code)		
FAX NO. (include area code)		

TIP: Fill in submitter information section and then make copies of the form.

Comments: This section is for any additional information or notes.

Other Information:

a. **Date of Collection** – (*Required by CLIA)* The date that the specimen was collected should be noted in this field.
b. **Clinic Type, Test Requested and Source of Specimen:** These fields have been pre-marked for your convenience.

Hepatitis B Information- Risk Factors (R.F.) Complete when ordering Hepatitis Testing

a. **Hepatitis B**
   i. Please mark any risk factors that apply to the TB clinic patient.
b. **Hepatitis C**
   i. Please mark any risk factors that apply to the TB clinic patient.
c. **HIV Risk Factors**
   i. Please mark any risk factors that apply to the TB patient

Mailing Instructions:

The Office of Laboratory Services provides testing supplies ordered by using the DI Supply Requisition Form that is available at www.dhhr.wv.gov/ols

Packaging provided by OLS meets all current DOT and Postal Regulations.

PREPARE BLOOD SPECIMEN(S) FOR MAILING

Using mailing tubes:

a. Place blood tube(s) in the inner plastic container (maximum 8 tubes per container).
b. Place 2 absorbent pads in the inner plastic container with the tubes.
c. Screw lid on plastic container.
d. Fold the DI requisition form in half, length- wise and wrap forms around the outside of the plastic container.
e. Place inner container and forms into outer container, apply postage and mail.
   - **The facility is responsible for the cost to ship the container to the Office of Laboratory Services.**

f. **Note: If your site is sending less than 8 tubes and concerned about the tubes 'rattling' around in the container, add some additional padding such as a paper towel to the inner container.**