West Virginia Department of Health and Human Resources
OFFICE OF LABORATORY SERVICES
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INSTRUCTIONS FOR THE COLLECTION, SUBMISSION FORM, AND MAILING OF BLOOD SPECIMENS

The Office of Laboratory Services (OLS) provides the following supplies in our collection kits:

1. 8.5mL SST blood tubes (gray and red top tubes)
2. Eclipse 21G needle hub assembly
3. Providers can access the "Requisition Form for Specimen Mailing Kits" from the OLS website: www.dhhr.wv.gov/ols
4. A copy of the Diagnostic Immunology test request submission form.
   - **TIP** – Facilities can fill in the submitter data section and then make copies of the form for use.
   - **TIP** – Some sites copy forms onto a specific color of paper for easy recognition. If your site chooses to do this, OLS recommends the use of pastel colors to prevent eye strain when filling out and performing data entry from the form.

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 best practice to provide one well-filled blood tube for each test type being requested **(1 for Syphilis, 1 for Rubella and 1 for HIV)**. However, if not possible two well-filled blood tube is acceptable for the lab to complete the blood testing.
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. Best practice is to gently invert the tubes after collection and allow the specimen to clot (20-30 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 ensure best results.
7. ***If your facility is unable to centrifuge the samples, contact the lab for more information*.**

Form Instructions:

PLEASE PRINT LEGIBLY.

The Clinical Laboratory Improvement Amendment of 1988 (CLIA) requires the following information for the lab to be able to process the specimen for testing. If any of this information is missing, by federal law, the lab cannot perform the test.

a. **A unique identifier on both the form and the specimen;**
b. **Address of submitter;**
c. **Date of birth or age of patient;**
d. **Sex of patient;**
e. **The test to be performed;**
f. **The source of the specimen (i.e. blood/serum, urine);**
g. **Date of collection;**
h. **Any additional information relevant to testing (i.e. information necessary by the program).**

NOTE: For your convenience, a fillable form is available on our website.

1. **Patient Information**
   - a. **Patient ID** --- This refers to a chart number, medical record number, or some other internal ID that your facility uses to identify patients. A maximum of 15 characters is allowed.
   - b. **Last Name, First Name, MI** --- Patients' full name (*information on tube and form must match)*
   - c. **Date of Birth** --- CLIA requires DOB or AGE of Patient
   - d. **Social Security Number** *(optional)* --- last 4 digits only
   - 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** --- at birth *(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)*
   - j. **Ethnicity** --- *(required by program)*

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	

2. **Submitter Information**
   - a. **Facility Name** --- The official name of the site as listed on the Memorandum of Understanding (MOU) or application to the STD program. **Do not use just 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)*
     NOTE: This will not appear in the address field on the final report.
   - 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.

3. **Comments** --- This section is for any additional information or notes.

4. **Date of Collection** --- (*required by CLIA)* The date that the specimen was collected.

DATE OF COLLECTION:

5. **Program/Clinic Type**

NOTE: At this time, patients being seen as part of the FAMILY PLANNING Program, are not eligible for HIV testing. Sites wanting to test FP patients for HIV must make separate arrangements with the HIV Program.

   - a. **APC (for anonymous HIV testing only)**
   - b. **College / University – FP** --- if your site is sponsored by the Family Planning Program.
   - c. **College / University – STD** --- if your site is sponsored by the STD Program.

d. Family Planning--- if your site has a MOU with the Family Planning Program and provides no charge testing to clients.

e. Hospital --- Sending samples to OLS for confirmation testing or diagnostic problem cases.

f. HIV Clinic --- if your site is an approved site for HIV testing and counseling.
*NOTE: HIV sites **MUST** have counselors that have completed a mandatory training course offered by the HIV program. For more information on the course contact the program at 1-800-642-8244.*

PROGRAM/CLINIC TYPE: (Select ONE Only)	
❑ APC (For anonymous HIV testing only)	❑ HIV Clinic
❑ College / University – FP	❑ Jail / Prison
❑ College / University – STD	❑ Juvenile Detention Center
❑ Family Planning	❑ STD Clinic / STD Services
❑ Hospital	❑ Project HRP
❑ Project # _____	

g. Jail / Prison --- if your site is approved to provide testing by the STD and HIV Programs.

h. Juvenile Detention Center --- if your site is approved to provide testing by the STD and HIV Programs.

i. STD Clinic / STD Services --- if your site provides STD testing at no charge to the patient.

j. Project HRP --- if your site provides syringe service or harm reduction services to patients.

k. Project # _____ --- for special projects such as outbreaks, investigations, or outreach events (*assigned by OLS*).

6. Test Requested (*required by CLIA*)

~~a. **CT/NG Amplified NAAT**~~

b. **HIV** --- HIV screening and confirmatory testing.

c. Rubella Screen --- Rubella antibody test to determine immunity.

d. Syphilis Screen --- RPR and titer with follow up confirmatory test if patient is reactive.

e. HIV confirmation Test --- ***This is specifically for sites enrolled in the Rapid HIV program*.**

TEST REQUESTED: (Select ONE Only)	
❑ ~~CT/NG Amplified NAAT~~	❑ Rubella Screen
	❑ Syphilis Screen (RPR)
❑ HIV Confirmation Test (*for Rapid HIV Program ONLY*)	❑ HIV

7. Source of Specimen
(mark the appropriate box on the form)

a. For Syphilis, Rubella, and HIV --- Blood/Serum

~~**b.** Urine~~

SOURCE OF SPECIMEN:	
❑ Blood / Serum	❑ ~~Urine~~

8. Is patient pregnant? – If yes, mark box and include due date.

Is patient pregnant? ❑ NO ❑ YES (due date _____)

NOTE: CT/NG Information – Reason for Test is covered in the "Instructions for the Collection, Submission Form, and Mailing of Chlamydia/Gonorrhea Urine Specimens" document.

9. HIV Information (Select ALL that apply) --- As noted, mark any risk factor that applies to the patient.

a. Risk Factors in the left colomn are for the patient.

b. Risk Factors in the right colomn are to be marked if the patient has had heterosexual relations with any partner that has the listed risk factors.

c. Place the HIV Barcode from the "HIV Test Form" provided by the HIV Program in the space indicated.

HIV INFORMATION: (Select ALL that apply)	
RISK FACTORS:	**HETEROSEXUAL RELATIONS WITH:**
❑ Sex with male	❑ IV injection drug user
❑ Sex with female	❑ Bisexual male
❑ Injected non-Rx drugs	❑ Person with hemophilia/clotting disorder
❑ Rec'd Clotting Factor F VIII A	❑ Transfusion recipient WITH documented HIV positive
❑ Rec'd Clotting Factor F IX B	❑ Transplant WITH documented HIV positive
❑ Blood transfusion	❑ Person with AIDS or documented HIV positive
❑ Rec'd transplant or artificial insemination	❑ Unspecified risk
❑ Healthcare worker and/or Lab worker	*PLACE HIV TEST FORM BARCODE LABEL HERE*

Mailing Instructions:

The Office of Laboratory Services provides testing supplies ordered by using the DI Supply Requisition Form that is available on our website or by calling 304-558-3530. Packaging provided by OLS meets current Department of Transportation (DOT) and all other federal regulations.

Preparing Specimen(s) for Mailing:

Using mailing tubes:

a. Place blood tube(s) in the inner plastic container (maximum 8 tubes per container).

b. Make sure that two (2) absorbent pads are 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 cardboard container, screw lid on container, apply postage, and mail.

At this time, the Office of Laboratory Services does not supply return postage for the shipment of specimens. The facility is responsible for the cost to ship the container to us for testing. If your facility is interested in setting up a FedEx account with reduced state contract pricing, please contact us for more details.

NOTE: If your site is sending less than eight (8) tubes and concerned about the tubes 'rattling' around in the container during transport, we suggest adding some additional padding such as a paper towel to the inner container.

Should you have any questions or need any additional information, please contact the Diagnostic Immunology Section at 304-558-3530 extension 2405 or 2407. Our normal business hours are Monday through Friday from 8:00am to 4:30pm. OLS is closed on weekends and state holidays.