West Virginia Department of HEALTH

Office of Laboratory Services
167 11th Avenue South Charleston, WV 25303-1114
Phone: (304) 558-3530 FAX: (304) 558-2006

Instructions for Submission Forms and Shipping of Blood Specimens: TB Clinics

OLS Provided Supplies

- OLS provides 8.5mL BD Vacutainer Serum Separator Tubes (SSTs)
  - Gray and Red Top
  - Tiger Top also called SST tubes
- Eclipse 21 gauge needle with holder assembly

For your convenience, a fillable form is available on our website: https://dhhr.wv.gov/ols/

Form Instructions

1. The Clinical Laboratory Improvement Amendment of 1988 (**CLIA**) requires the following information for the lab to be able to process the specimen for testing.
2. **If any of the following 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 (at birth) of patient
   E. Test to be performed
   F. Source of specimen
      i. Only one source option
      ii. Blood/serum
   G. Date of collection
      i. It is best practice if the date of collection is placed on the form and specimen
      ii. In the case of discrepancies, the specimen date of collection will override the form
   H. Any additional information relevant to testing
      i. Previous test(s) results
      ii. Information required by programs
      iii. Court order testing (please send copy of the court order for our records)
3. Please print legibly, using an ultra fine Sharpie/permanent marker, if not using a printed label

Current Forms Available:

All forms revised 01/2024.

The most current form must be used or the specimen will be rejected.

TIP: Some facilities and providers copy forms onto a specific color of paper for easy recognition for their staff. If your site chooses to do this, OLS recommends the use of pastel colors to prevent eye strain when entering data from the form.

TB CLINIC FORM ONLY	DIAGNOSTIC IMMUNOLOGY LABORATORY SPECIMEN SUBMISSION FORM	TB CLINIC FORM ONLY
USE ONE FORM PER SPECIMEN		

NOTE: TB Clinics may only use this form for specimen submission. If TB clinics use any other forms, the facility will be charged for testing under "Fee for Service."

NOTE: If the TB clinic is used for any other type of patient or clinics, samples will be rejected. Non-TB clinics are NOT to use this form.

REQUIREMENT: One form must be submitted for each TB clinic test type being requested.

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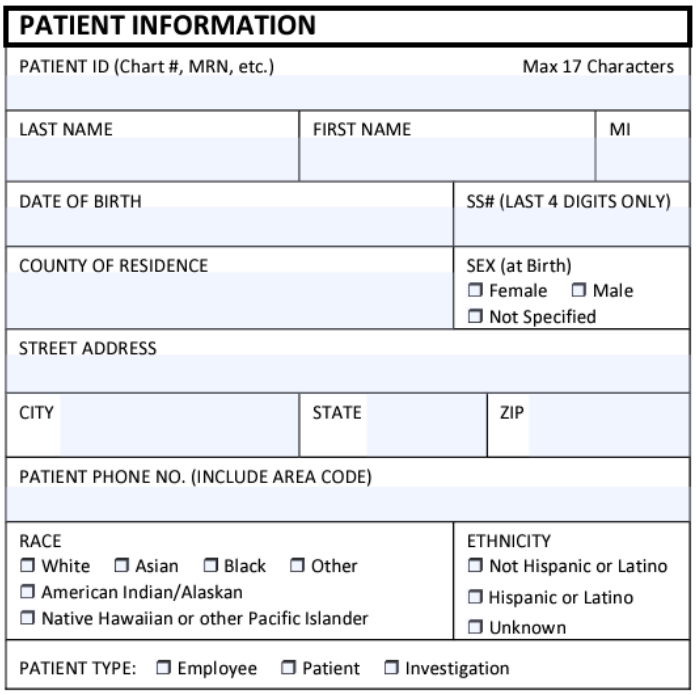
Patient Information



PATIENT INFORMATION

PATIENT ID (Chart #, MRN, etc.) Max 17 Characters

LAST NAME | FIRST NAME | MI

DATE OF BIRTH | SS# (LAST 4 DIGITS ONLY)

COUNTY OF RESIDENCE | SEX (at Birth) ❒ Female ❒ Male ❒ Not Specified

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: ❒ Employee ❒ Patient ❒ Investigation

1. Patient ID
   A. Refers to a chart number, medical record number, or some other internal ID that your facility uses to identify patients.
   B. A maximum of 17 characters is allowed.
2. Last Name, First Name, MI
   A. Patients' full name on form and tube must match
   B. Mismatch will result in a rejection of your specimen
3. Date of Birth- **CLIA required**
   A. DOB **OR**
   B. Age
4. Social Security Number
   A. Optional
   B. Last 4 digits only
5. Sex (at birth)- **CLIA and State HIV and Hepatitis Programs required**
   A. Mark "not specified" if the patient does not provide this information.
   B. If blank, OLS will mark and document as "not specified".
   C. The OLS Central Accessioning/Support Services group will not assume sex of the patient at birth.
6. Patient Type
   A. Patient type has been filled in for your convenience.
   B. There is only one patient type eligible for selection.
7. **The following sections of the form are requirements of the State HIV and Hepatitis Programs**
   A. County of Residence
   B. Street address, city, state, zip code
   C. Patient Phone Number with area code
   D. Race (more than one can be selected)
   E. Ethnicity

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Submitter Information

1. Facility Name- **CLIA required**
   A. The official name of the site as listed on the Memorandum of Understanding (MOU) or application to the STD Program.
   B. Do not use just the initials of your site.
2. Street Address, City, State, Zip Code- **CLIA required**
   A. Must be the site at which the services are provided
3. County- **State HIV and Hepatitis Programs required**
   A. Location of submitter
4. Attention To
   A. This line is to be filled out if the results are to go to a specific individual or department within the facility
   B. This will not appear in the address field on the final report
5. Phone Number- **State HIV and Hepatitis Programs required**
   A. Include area code
   B. Required for potential contact/counseling purposes
6. Fax Number
   A. Include area code
   B. Must be a secure fax where only credentialed individuals within your facility can access
7. Comments Box
   A. Use this section to relay information to Central Accessioning/Support Services and DI Unit.
   B. Note if patient has any previous testing results
   (i.e. RPR titer, TPPA, Hepatitis B, etc.).
   C. Any information the provider believes to be relevant to the patient sample for testing.
   D. May be used to note communication between you and OLS staff members if special instructions have been provided.

SUBMITTER INFORMATION		
The information below is for the mailing or faxing of test reports. Please make sure the mailing address and fax number are accurate. OLS should be notified of any changes to this information as soon as possible.		
FACILITY NAME		
MAILING ADDDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO		
PHONE NO. (INCLUDE AREA CODE)		
FAX NO. (INCLUDE AREA CODE)		

NOTE: OLS considers the provided facilities' fax numbers as secure locations only accessible by credentialed individuals.
OLS is NOT responsible for patient results after delivery to the facility is complete.

Provider and /or OLS notes:

Date of Collection- Required by CLIA

1. Date the specimen was collected
2. Best practice to indicate on both the form and all specimen tubes

DATE OF COLLECTION:	

NOTE: If a discrepancy arises with the date of collection, the date of collection on the specimen tube will override the form.

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Program/Clinic Type

1. TB Clinics are the only facilities eligible to submit no charge testing using this form.
2. This has been prefilled for your convenience.

PROGRAM/CLINIC TYPE (SELECT ONE ONLY)		
☑ TB CLINIC (NO CHARGE TESTING)		
TEST REQUESTED (SELECT ONE ONLY)		
☑ HEPATITIS B PANEL	☑ HEPATITIS C PANEL	☑ HIV PANEL
SOURCE OF SPECIMEN:		
☑ BLOOD / SERUM		

Test Requested- Required by CLIA

1. TB Clinic patients are only eligible for the following tests. This has been prefilled for your convenience.
2. Hepatitis B Screen
   A. Surface Antigen (sAg)
   B. Core Antibody (cAb)
3. Hepatitis C Antibody Screen
4. HIV Screen
   A. HIV Ag/Ab: Specimen must be less than 3 days old
   B. HIV 1-2, O: Specimen must be less than 7 days old

Source of Specimen

1. TB Clinic tests require only blood/serum sources for specimens.
2. This has been prefilled for your convenience.

REQUIREMENT: All blood specimens currently have an **expiration date of seven (7) days** from the moment blood hits the SST tube.

Day 1 = moment blood hits the tube

Is the patient pregnant?

1. If "Yes": include the due date for State STD Program purposes. Mark "No" for non-pregnant females.
2. For male patients, mark N/A

IS PATIENT PREGNANT? ❒ N/A ❒ NO ❒ YES: DUE DATE _____

NOTE: A risk factors reminder bulletin has been created on the following page.

RECOMMENDATION: Print the following page and place within your facility at locations where the submission forms are most likely to be filled out.

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Risk Factors- Required for ALL testing purposes and clinic types

1. There are **three (3) boxes** of risk factors on the TB Clinic form.
2. Marking less than **all three (3) boxes** of risk factors is **NOT** acceptable.
3. **OLS will NOT ASSUME the patient has the same risk factors for Hepatitis B, Hepatitis C, or HIV if any one of the risk factors boxes are left blank.**
4. Risk factors must have occurred within the previous 12 months in order to be listed.
5. Mark all risk factors that apply to the patient for each requested test:
    A. Hepatitis B
    B. Hepatitis C
    C. HIV
6. HIV Barcode
    A. Place the HIV barcode from the "HIV Test Form" provided by the HIV program in the space indicated
    B. All HIV tests should have a barcode label provided by the HIV program
    C. Contact the HIV program at (304) 558-2195 or 1 (800) 442-8244 to order HIV Program forms and barcodes.

HEPATITIS B INFORMATION: RISK FACTORS	
❒ Body piercing (non-commercial)	❒ Multiple Partners
❒ Tattoo (non-commercial)	❒ Healthcare Worker
❒ Needle stick / blood splash	❒ Current non-IV drug user
❒ Currently injecting drugs	❒ Blood transfusions
❒ History of Incarceration	❒ Hemodialysis
❒ Symptoms / Diagnosis of STD	❒ Sexual contact
❒ Household Contact	

HEPATITIS C INFORMATION: RISK FACTORS	
❒ Contact with POSITIVE+ Hepatitis C patient	
❒ Body piercing (non-commercial)	❒ Multiple Partners
❒ Tattoo (non-commercial)	❒ Healthcare Worker
❒ Needle stick / blood splash	❒ Current non-IV drug user
❒ Currently injecting drugs	❒ Blood transfusions
❒ History of Incarceration	❒ Hemodialysis
❒ Symptoms / Diagnosis of STD	❒ Sexual contact
❒ Household Contact	

RISK FACTOR INFORMATION (SELECT ALL THAT APPLY)	
PATIENT RISK FACTORS	**PARTNER RISK FACTORS**
❒ Sex with female	❒ Bisexual female
❒ Sex with male	❒ Bisexual male
❒ Injected non-RX drugs	❒ IV injection drug user
❒ Rec'd clotting Factor F VII A and/or F IX B	❒ Person with AIDS or documented HIV+
❒ Received transplant or artificial insemination	❒ Transfusion recipient WITH documented HIV+ and/or transplant WITH documented HIV+
❒ Blood transfusion	❒ Person with hemophilia/clotting disorder
❒ Healthcare worker and/or laboratory worker	**PLACE HIV TEST FORM BARCODE LABEL HERE**
❒ Unspecified Risk(s)	