

## SPECIMEN SUBMISSION GUIDELINES

HIV Diagnostics and Reference Laboratory, Diagnostics and Countermeasures Branch  
 Center for Infectious Disease Research, Walter Reed Army Institute of Research  
 508 Research Drive, Silver Spring, MD 20910

### Hepatitis B Surface Antigen Test Request Form

Test Requested	Specimen Requirement	Draw Tube	Shipping Conditions (Check one)
<input type="checkbox"/> <b>HBsAg Confirmatory</b>	<input type="checkbox"/> 3 ml serum (SST Tubes)  or  <input type="checkbox"/> 3 ml plasma (EDTA, Na Heparin, Na Citrate, CPDA and ACD-1 plasma is acceptable.)	<p><b>SST Tubes</b> – Invert 5X and allow to clot for 30 min (no more than 2 hrs) post-collection. Centrifuge 10 minutes at 1000-1300 RCF in a swing bucket centrifuge.</p> <p><b>NOTE:</b> Tubes MUST be allowed to clot for 30 minutes.</p> <p><b>PPT Tubes</b> – Invert 8-10X. Stable at RT up to 6 hrs. Centrifuge in swing-out rotor centrifuge at 1100 RCF for a minimum of 10 min. Freeze plasma aliquot at -20°C.</p>	<input type="checkbox"/> <b>Ambient 15-30°C</b> – SST tube must be received at HDRL within 7 days of collection.  <input type="checkbox"/> <b>Refrigerated 2-8°C</b> – SST tube must be shipped in cold box with ice packs and received at HDRL within 7 days of collection.  <input type="checkbox"/> <b>Frozen -20°C</b> – Ship frozen <b>aliquoted</b> plasma with dry ice if specimen will be received at HDRL after 7 days of collection.

**Please fill the request form completely to ensure timely specimen processing.**

PATIENT IDENTIFICATION	CONTACT INFORMATION
<p><b>Patient identifiers <u>MUST INCLUDE</u>:</b></p> <p>Full Name _____</p> <p>DoDID _____</p> <p style="text-align: center;">OR</p> <p>FMP/SSN _____</p> <p>DOB _____</p> <p>Specimen Draw Date / Time: _____</p> <p>Ship Date: _____</p>	<p>POC _____</p> <p>Physician Name _____</p> <p>Clinic / Center _____</p> <p>Center Address _____</p> <p>_____</p> <p>_____</p> <p>Telephone Number _____</p> <p>Fax Number _____</p> <p>(Commercial # only; please include area/country code)</p> <p>Alternate POC Name _____</p> <p>Alternate POC Phone _____</p>

PROCESSING LABORATORY (For HDRL use only)

BARCODE	DATE RECEIVED	QUANTITY & TYPE RECEIVED / INITIALS

**Fax/Email a FedEx tracking and/or invoice number to ensure all shipments sent to the HIV Diagnostics and Reference Laboratory are received, IAW CAP GEN.40530**  
**Shipping Address: 9100 Brookville Road, BLDG 508, Silver Spring, MD 20910**