



**CENTRE FOR TUBERCULOSIS RESEARCH
(NATIONAL TUBERCULOSIS REFERENCE LABORATORY)**

M0588A

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Specimen Examination Request Form for Tuberculosis (to be completed by requesting facility)

Specimen Identification No: *(For Official Use Only)* _____

Name of Patient: _____

Age: _____ Date of Birth: _____ Sex (Tick one) M F Tel No _____

Patient address: _____

E-mail address: _____

HIV Status: Positive Negative Unknown

Name of Health Facility: _____

Health Facility Address: _____

Reason for examination (Tick one): Diagnosis Follow-up examination Month of Follow-up

Others (specify): _____

Test request needed (Tick any):

*Xpert MTB/RIF <input type="checkbox"/>	*Smear for AFB <input type="checkbox"/>
*Solid Culture <input type="checkbox"/>	*Liquid Culture <input type="checkbox"/>
*1 st line LPA <input type="checkbox"/>	*2 nd lines LPA <input type="checkbox"/>
*1 st line DST (Solid) <input type="checkbox"/>	*2 nd line DST (Solid) <input type="checkbox"/>
*1 st line DST (Liquid) <input type="checkbox"/>	*2 nd line DST (Liquid) <input type="checkbox"/>

Others specify _____

Note: All asterisks are accredited

Type of specimen: _____ Date of specimen collection: _____

Time of specimen collection: _____ Number of specimens sent with form: _____

Name of Person requesting examination: _____ Signature: _____

Phone Number: _____ E-mail Address: _____

Kindly indicate how result will be sent (Tick as apply): E-mail Pick-up

Note 2: Please note that a consent form is available for your review

For Official Use Only

Specimen Received By: _____ Date: _____ Time: _____

Type of Specimen Received: _____

Sample Accepted: Yes No

If No (Reason): _____