TB DIAGNOSTICS LABORATORY REQUEST FORM

TB LABORATORY **MRC UNIT THE GAMBIA**	**Section 1. PATIENT INFORMATION** **NAME or (Participant ID)**
SUSPECTED DIAGNOSIS	*Last* *First* **BIRTH DATE** / / **AGE** **SEX** *dd mm yr*
STUDY NUMBER	**MRC NUMBER** **SOURCE** **CHARGE CODE**

NEW CASE							
FOLLOW-UP		**IF YES, IS PATIENT ON THERAPY?**	**YES**	**NO**	(*Circle one*)		
		IF YES, SPECIFY DRUGS	**INH**	**RIF**	**PYRAZ**	**ETH**	(*Circle all that apply*)

PATIENT'S FULL ADDRESS:	
AREA:	**TOWN/VILLAGE**
COMPOUND:	
STREET No & NAME:	**TELEPHONE No:**
DIRECTIONS:	
CONTACT PERSON: (NAME)	**(TELEPHONE No)**

Section 2. ORDERING PHYSICIAN INFORMATION	
NAME **Signature** **ext**	**REQUEST DATE**

Section 3. SPECIMEN INFORMATION (Please mark appropriate box with "X")

☐ **Sputum 1** ☐ **Sputum 2** ☐ **OTHER** (*Specify*).....

SPECIMEN COLLECTED BY	**DATE** / /	**TIME** /
	dd mm yr	*hr: mm*

This report is in compliance with SOP-TBL-001, 004, 005, 006, 007, 009, 010, 011

REQUEST: ☐ ***AFB** ☐ ***AFB + CULTURE** ☐ **GENEXPERT**

Section 4. FOR LABORATORY ONLY	
SPECIMEN ACCEPTED **YES/NO**	**SPECIMEN RECEIVED BY:** .....
RESULTS (MICROSCOPY) **AU: .....**	**LAB No:**

LAB TECH SIGN & DATE	**SUPERVISOR SIGN &DATE**	**DATE/TIME STAMP HERE:**

*KENAS Accredited Assay