

	<b>MYCOBACTERIOLOGY</b> <b>PUBLIC HEALTH LABORATORY TEST REQUEST</b>	<b>FOR LAB USE ONLY</b>
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**Please print clearly:** DATE\* (MM/DD/YYYY):  **\*Required information**

**1. PATIENT INFORMATION**

PATIENT LAST NAME*:		PATIENT FIRST NAME*:	
<input style="width:100%;" type="text"/>		<input style="width:100%;" type="text"/>	
DATE OF BIRTH* (MM/DD/YYYY):	Sex*: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	PATIENT ID#/MEDICAL RECORD#:	
<input style="width:100%;" type="text"/>		<input style="width:100%;" type="text"/>	
ADDRESS:	CITY:	STATE:	ZIP:
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
TELEPHONE:	PHYSICIAN: (if other than submitter)	Physician's pager/cell:	
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	

**2. SUBMITTER INFORMATION**

NAME OF SUBMITTING HOSPITAL, LABORATORY, or OTHER FACILITY Etc.*:		PROVIDER ID#:	
<input style="width:100%;" type="text"/>		<input style="width:100%;" type="text"/>	
PRIMARY CONTACT or PHYSICIAN- LAST NAME*:		FIRST NAME*:	
<input style="width:100%;" type="text"/>		<input style="width:100%;" type="text"/>	
ADDRESS*:			
<input style="width:100%;" type="text"/>			
CITY*:	STATE*:	ZIP*:	
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	
TELEPHONE*:	Pager/Cell*:	Fax:	EMAIL:
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>

**3. SPECIMEN INFORMATION**

DATE OF COLLECTION* (MM/DD/YYYY) <input style="width:100px;" type="text"/>		TIME OF COLLECTION* [00:00] (where applicable): <input style="width:100px;" type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	
Reason for submission*	<input type="checkbox"/> DIAGNOSTIC <input type="checkbox"/> CONFIRMATORY <input type="checkbox"/> FOLLOW UP <input type="checkbox"/> BTBC REQUEST (if checked, complete A)		
A. BTBC contact	Last Name: <input style="width:100px;" type="text"/>	First Name: <input style="width:100px;" type="text"/>	BTBC EVENT CODE: <input style="width:100px;" type="text"/>
Is this submission for referral?*	<input type="checkbox"/> NO <input type="checkbox"/> YES (IF YES CHECK ONE): <input type="checkbox"/> NYS <input type="checkbox"/> CDC <input type="checkbox"/> Nat' Jewish <input type="checkbox"/> OTHER (specify): <input style="width:100px;" type="text"/>		
Specimen type*	<input type="checkbox"/> Primary specimen <input type="checkbox"/> Isolate [Date of ID-MM/DD/YYYY]: <input style="width:100px;" type="text"/>		
Specimen source*	<input type="checkbox"/> Sputum <input type="radio"/> Induced <input type="radio"/> Expectorated <input type="checkbox"/> Bronchial washing <input type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Lymph node <input type="checkbox"/> Pleural <input type="checkbox"/> **Tissue <input type="checkbox"/> **Other **Specify type <input style="width:100px;" type="text"/>		
Referring Laboratory*	Specimen Accession #: <input style="width:100px;" type="text"/>		
Additional test information*	<input type="checkbox"/> First Time Diagnosis <input type="checkbox"/> TB Drug therapy, 7 days or more: <input type="checkbox"/> Yes <input type="checkbox"/> No <b>MTD will not be performed on smear negative specimens nor on a patient on TB drug therapy for 7 or more days without written physician justification submitted with this form.</b> Has this patient been previously positive for MTB? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes indicate CRS #) <input style="width:100px;" type="text"/> Does this patient have a TB isolate known to be resistant to anti-tuberculosis drug(s) <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, specify) <input style="width:100px;" type="text"/> Is this patient currently on antimycobacterial therapy? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, indicate# <input style="width:100px;" type="text"/> of <input type="radio"/> Days <input type="radio"/> Weeks <input type="radio"/> Mos)		

**4. TEST(S) REQUESTED\***

<input type="checkbox"/> ID & Susceptibility <sup>1</sup> (clinical specimen)	<input type="checkbox"/> Referral culture: Susceptibility ONLY
<input type="checkbox"/> Referral culture: ID & Susceptibility	<input type="checkbox"/> Therapeutic Drug Monitoring (specify): <input style="width:100px;" type="text"/>
<input type="checkbox"/> Referral culture; ID ONLY	<input type="checkbox"/> Referral culture for Molecular Typing (Referral for DNA Typing has been requested by DOHMH on ALL first time positive patients)
<input type="checkbox"/> MTD Identification & Susceptibility: Date of smear positive required for test: (MM/DD/YYYY): <input style="width:100px;" type="text"/>	

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<sup>1</sup> Susceptibility testing will routinely be performed for first line drugs. If prior resistance has been documented or is found to more than one first line drug(s), second line drug susceptibility testing will be performed.

\*Failure to provide the required information or any discrepancy relating to the specimen submitted, may result in an inability to test or a delay in the release of test results.