REPUBLIC OF KENYA

MINISTRY OF HEALTH

NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE

Specimen

DRUG RESISTANCE TUBERCULOSIS LAB MONITORING FORM

ALL FIELDS ARE MANDATORY

County: _____ Sub-County: _____ Facility Name: _____ MFL Code: _____

PATIENT IDENTIFICATION	CONTACT INFORMATION
Patient Name*: _____	Clinician Name*: _____
TB / MDRTB Register No*: _____	Clinician Mobile No*: _____
DOB/Age*: _____	SCTLC Name*: _____
Sex*: ☐ Male ☐ Female	SCTLC Email*: _____
Patient mobile No*.: _____	SCTLC Mobile No*: _____
	SCMLC Email *: _____

Indicate/Tick as appropriate

☐ Baseline Test ☐ Follow up Investigation ☐ Month of Treatment

SPECIMEN COLLECTION DETAILS

Date Collected*: _____ Time*: _____ Collected By*: _____

SPECIMEN TYPE

☐ Blood* Others (Specify) _____

TEST REQUESTED

☐ Full Blood Count* ☐ Creatinine* ☐ RBS* ☐ Pregnancy Test* ☐ TSH*

☐ Potassium* ☐ Magnesium* ☐ LFTs(AST, ALT & Bilirubin)* ☐ Albumin*

Others (specify) _____

Note: Additional/Other test require approval

Lab Receipt

☐ Purple Top* ☐ Red/Yellow Top* ☐ Cryovial*

Received By*: _____ Date*: _____ Time*: _____

Specimen