Specimen

REPUBLIC OF KENYA

MINISTRY OF HEALTH

NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE PROGRAM/NATIONAL TUBERCULOSIS REFERENCE LABORATORY

LABORATORY REQUEST FORM

******ALL FIELDS ARE MANDATORY******

PATIENT INFORMATION

Full Name (3 Names)*: ______________________ Age*: ____________ Sex*: Male ☐ Female ☐

Mobile No*.: ________________ Alternative Mobile No*: ______________ National Identification / NEMIS No*: __________

Physical Address*: ____________ Ward/Department*: ________ IP/OP Number*: ________ TB / MDRTB Register No*: ________

REQUESTER DETAILS

Name of facility*: ________________ Sub County*: ____________ County*: ____________ MFL CODE*: ________

Name of clinician*: ____________ Facility/clinician Phone Number*: ____________ Facility/clinician Email*: ________________

Name of SCTLC*: ______________ SCTLC Phone number*: ______________ SCTLC Email*: ____________________

CMLC/SCMLC Name*: ______________________ CMLC/SCMLC Email address*: ______________________

RELEVANT CLINICAL INFORMATION (Tick (√) where appropriate)

Type of Patient:	HIV Status	Type of TB: DS TB	Type of TB: DR TB
New ☐ Treatment after loss follow up ☐ Relapse ☐ Previous Treatment History unknown ☐ Treatment after Failure ☐ Others previously treated ☐	Positive ☐ Negative ☐ Declined ☐ Not done ☐ Date tested: ____/_____/_______	PTB ☐ EPTB ☐ TB Adenitis ☐ Skeletal TB ☐ TB Meningitis ☐ Other (Specify) ______________	INH Mono Resistant ☐ RR ☐ MDR ☐ Poly drug resistant ☐ **Specify**________________ Pre XDR ☐ XDR ☐

Reasons for Examination (Tick (√) where appropriate)

Drug sensitive TB: New ☐ Follow up 2 Months ☐ 3 months ☐ 5 months ☐ 6 months ☐

Drug resistant TB: Baseline ☐ Follow up ☐ Specify Month of follow up: __________________________

SAMPLE DETAILS (Tick (√) where appropriate)

Sample type	Test requested:	
Sputum ☐ CSF ☐ Gastric aspirate ☐ Pleural fluid ☐ Stool ☐ Urine ☐ Ascitic fluid ☐ FNA ☐ Lymph node biopsy ☐ Nasopharyngeal aspirate ☐ Others: _____________	Smear Microscopy ☐ GeneXpert ☐ First Line LPA ☐ Second Line LPA ☐ Culture ☐ DST First Line ☐ DST Second Line ☐	**Other Tests** TB LAM ☐ Sequencing ☐ BD MAX ☐ TRUENAT ☐ **Interferon Gamma Release Assay (IGRA):** a) Quantiferon ☐ b) T- spot ☐

Date of sample collection: ____/_____/_____ **Time:** ______________ **Date sample received at testing lab:** ____/_____/______ **Time:** ______________

LAB REPORT (LAB USE ONLY)

Date: ____/_____/_______ **Time Sample Tested:** ____________________ **Method used:** ZN ☐ FM ☐ Xpert ☐

Lab serial no.	Specimen type	Visual Appearance	Results								
			Neg	Actual no.	+	++		Xpert results**	TB LAM	Others: __________	Date & Time dispatched
									Pos ☐ | Neg ☐		

**select one of the following	
TS: MTB detected Rif resistance not detected	**N:** MTB not detected
RR: MTB detected & Rif resistance detected	**I:** Invalid/No results/Error
TI : MTB detected Rif resistance indeterminate	**Tr:** MTB detected Trace

Examined by (Name and Signature) ______________________ Laboratory Name ________________ Date____/_____/______

Reviewed by (Name and Signature) ______________________ Laboratory Name ________________ Date____/_____/______

Specimen