Lab Use Only

☐ **Acceptance Criteria Not Met**
- ☐ Inappropriate temperature
- ☐ Specimen too old
- ☐ Incomplete labeling/form
- ☐ Specimen inappropriate/damaged

Date: ____/____/_____ Initials:_____

MYCOBACTERIOLOGY (TB)

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive
Raleigh, NC 27607

Please Give All Information Requested *Attach Printed Label Below*

Patient Information

Last Name				
First Name	MI			
Maiden Name/Surname				
Address/Attention:				
Street Address:			Address 2:	City:
State:	Zip Code:	County Code:	County Name:	Phone Number:
Insurance ID Number: (if applicable) _____			Medicaid Number (if applicable): __ __ __ __ __ __ __ __ __ __	
Medical Record Number:			Date of Birth: ____/____/_____	

Sex:
- ◯ Male
- ◯ Female
- ◯ Unknown
- ◯ Ambiguous
- ◯ Transgender M2F
- ◯ Transgender F2M
- ◯ Transgender Unknown

Race (mark all that apply):
- ☐ White
- ☐ Black
- ☐ Asian
- ☐ Unknown
- ☐ American Indian/ Alaska Native
- ☐ Native Hawaiian/ Pacific Isles

Ethnicity:
- ☐ Hispanic or Latino Origin
- ☐ Non-Hispanic
- ☐ Unknown

Submitter

EIN: _____-_____	Submitter Name:	
Address:	Address 2:	City:
State:	Zip Code:	County Name:
Phone Number:	Email Address:	Fax Number:
Ordering Provider NPI:	Ordering Provider First and Last Name:	

Specimen

Collection Date: ____/____/_____ Collection Time: ____:____ 24 Hr Time

Reason for Testing (ICD-10 Dx Code): __ __ __ __ __ __ __

Specimen Type:

☐ **Clinical**

☐ **Reference**

Specimen Source:
- ☐ Natural Sputum
- ☐ Inducted Sputum
- ☐ Bronchial Wash
- ☐ Urine
- ☐ Other: _____

Laboratory Number:

Do Not Write in this Space

Continued on back of form

Other

Previously Diagnosed?

M. tuberculosis ☐ Yes ☐ No

☐ Other Mycobacteria (specify) _____

Is Patient on Respiratory Isolation? ☐ Yes ☐ No

Drug Therapy: ☐ None

☐ INH ☐ SM ☐ PZA ☐ RIF

☐ Other: _____

Date Drug Therapy Started: ___/___/____

Risk Factors:

☐ HIV Positive ☐ Cough > 2 Weeks

☐ Immigrant from high-incidence country?

☐ Direct contact to TB Case ☐ IV Drug User

☐ Other: _____

Signs/Symptoms:

☐ Cough ☐ Fever, Chills, Night Sweats

☐ Significant Weight Loss ☐ Hemoptysis

☐ Other: _____

Other - References Only

Culture Identification Number _____

When submitting reference cultures for confirmation and/or identification, supply as much of the requested information as is applicable. This will expedite the identification process.

Biochemical Test Reactions:

☐ Niacin ☐ Tellurite Reduction ☐ Urease

☐ Nitrate Reduction ☐ Tween 80 ☐ MacConkey

☐ Catalase - 25° ☐ Arylsufatase –3 days ☐ 5% NaCl

☐ Catalase - 68°, pH7 ☐ Arylsufatase – 2 weeks ☐ Iron Uptake

Culture Submitted Is:

☐ Original Culture: Planted _____

☐ Pure culture of _____ ☐ Subcultured _____

Original Smear Result: _____

Number of Cultures Positive with this Organism: _____

Colony Morphology on 7H10 Agar Plate: _____

Microscopic Description: _____

Other Observations: _____

DNA Probe Results _____

Other Test Results: _____