_							
3	☐ Acceptance Criteria Not Met						
Õ	☐ Inappropriate temperature ☐ Specimen too old ☐ Incomplete labeling/form						
Ф							
S							
7 (\square Specimen inappropriate/damaged						
Lat	Date:						

MYCOBACTERIOLOGY (TB)

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

Attach Printed Label Pole

	Please Give All II	nionnation Requ	Jestea		<i>F</i>	Attach Printed Label Below			
	Last Name								
Patient Information	First Name				MI				
	Maiden Name/Surname								
	Address/Attention:								
	Street Address:					Address 2:	City:		
	State: Zip Code: County Co			ode:		County Name:	Phone Number:		
	Insurance ID Number: (if applicable)					Medicaid Number (if applicable):			
	Medical Record Number:				Date of	Birth: / /			
	Sex: Male Transgender M2F Female Transgender F2M Unknown Transgender Unknown Ambiguous				Race (mark all that apply): White American Indian/ Black Alaska Native Native Hawaiian/ Unknown Pacific Isles		☐ Hispanic or Latino Origin☐ Non-Hispanic		
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:				
	Collection Date: Collection Time: 24 Hr			Reason for Testing (ICD-10 Dx Code):					
	Specimen Type:			Specimen Source:					
L	☐ Clinical			□ Natural Sputum □ Inducted Sputum □ Bronchial Wash □ Urine					
me				Other:					
Specimer				Laboratory Number:					
						Do Not Write in th	nis Space		

Continued on back of form

	Previously Diagnosed?	Drug Therapy: None			
Other	M. tuberculosis ☐ Yes ☐ No	□ INH □ SM □ PZA □ RIF			
	☐ Other Mycobacteria (specify)	□ Other:			
	Is Patient on Respiratory Isolation? ☐ Yes ☐ No	Date Drug Therapy Started: / /			
	Risk Factors:	Signs/Symptoms:			
	☐ HIV Positive ☐ Cough > 2 Weeks	☐ Cough ☐ Fever, Chills, Night Sweats			
	☐ Immigrant from high-incidence country?	☐ Significant Weight Loss ☐ Hemoptysis			
	☐ Direct contact to TB Case ☐ IV Drug User	□ Other:			
	□ Other:				
eferences Only	Culture Identification Number	Biochemical Test Reactions:			
		□ Niacin □ Tellurite Reduction □ Urease			
	When submitting reference cultures for confirmation and/or identification, supply as much of the requested information as is	□ Nitrate Reduction □ Tween 80 □ MacConkey			
	applicable. This will expedite the identification process.	☐ Catalase - 25° ☐ Arylsufatase —3 days ☐ 5% NaCl			
		☐ Catalase - 68°, pH7 ☐ Arylsufatase – 2 weeks ☐ Iron Uptake			
fere	Culture Submitted Is:	Colony Morphology on 7H10 Agar Plate:			
Other - Re	☐ Original Culture: Planted	Microscopic Description:			
	☐ Pure culture of ☐ ☐ Subcultured	Other Observations:			
	Original Smear Result:	DNA Probe Results			
	Number of Cultures Positive with this Organism:	Other Test Results:			