



Identification Code: SOP-TBL-005
Version: 5.0: 07 November 2016

Attachment 1



TB DIAGNOSTICS LABORATORY REQUEST FORM

TB LABORATORY MRC UNIT THE GAMBIA		Section 1. PATIENT INFORMATION					
SUSPECTED DIAGNOSIS		NAME or (Participant ID)					
		BIRTH DATE		AGE		SEX	
		/ /					
		Last		First			
		dd mm		yr			
STUDY NUMBER		MRC NUMBER		SOURCE		CHARGE CODE	
NEW CASE							
FOLLOW-UP		IF YES, IS PATIENT ON THERAPY?	YES	NO	(Circle one)		
		IF YES, SPECIFY DRUGS	INH	RIF	PYRAZ	ETH	(Circle all that apply)
PATIENT'S FULL ADDRESS:							
AREA:				TOWN/VILLAGE			
COMPOUND:							
STREET No & NAME:				TELEPHONE No:			
DIRECTIONS:							
CONTACT PERSON: (NAME)				(TELEPHONE No)			
Section 2. ORDERING PHYSICIAN INFORMATION							
NAME		Signature			ext		REQUEST DATE
Section 3. SPECIMEN INFORMATION (Please mark appropriate box with "X")							
<input type="checkbox"/> Sputum 1		<input type="checkbox"/> Sputum 2		<input type="checkbox"/> OTHER (Specify).....			
SPECIMEN COLLECTED BY		DATE		TIME			
		/ /		/ /			
		dd mm yr		hr: mm			
This report is in compliance with SOP-TBL-001, 004, 005, 006, 007, 009, 010, 011							
REQUEST:		<input type="checkbox"/> *AFB		<input type="checkbox"/> *AFB + CULTURE		<input type="checkbox"/> GENEXPERT	
Section 4. FOR LABORATORY ONLY							
SPECIMEN ACCEPTED		SPECIMEN RECEIVED BY:					
YES/NO						
RESULTS (MICROSCOPY)					LAB No:		
AU:							
LAB TECH SIGN & DATE		SUPERVISOR SIGN & DATE			DATE/TIME STAMP HERE:		

*KENAS Accredited Assay