MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
MISSOURI STATE PUBLIC HEALTH LABORATORY

TUBERCULOSIS TEST REQUEST

101 NORTH CHESTNUT STREET, PO BOX 570
JEFFERSON CITY, MO 65101
(573) 751-3334
http://health.mo.gov/lab/

GROWTH DETECTION AND ISOLATE IDENTIFICATION

- ☐ Acid-Fast Bacilli (AFB) Smear, Culture & Identification
- ☐ Acid-Fast Bacilli (AFB) Identification
- ☐ *M. tuberculosis* Complex Genotyping Purposes Only
- ☐ *M. tuberculosis* Complex DNA Sequencing with MDR-TB Screening: Rifampin (*rpo*B), Isoniazid (*kat*G, *inh*A, *ahp*C)

Accession Number Barcode
(For SPHL use only)

ANTIMICROBIAL SUSCEPTIBILITY TESTING FOR MTB COMPLEX

- ☐ *M. tuberculosis* Complex Antimicrobial Susceptibility Testing First-Line Drugs: Isoniazid, Rifampin, Ethambutol & Pyrazinamide
- ☐ *M. tuberculosis* Complex Molecular Detection of Drug Resistance: Rifampin (*rpo*B), Isoniazid (*kat*G, *inh*A, *ahp*C), Fluoroquinolones (*gyr*A), Amikacin, Kanamycin, Capreomycin (*rrs*)

SPECIMEN INFORMATION (ONLY one sample per form)

SPECIMEN TYPE (CHECK ONLY ONE)

☐ Clinical Specimen (unprocessed) ☐ Clinical Specimen (processed) ☐ Clinical Isolate

SPECIMEN SOURCE (CHECK ONLY ONE)

☐ BAL ☐ Sputum ☐ Pleural Fluid ☐ Blood ☐ Tracheal Aspirate ☐ CSF ☐ Urine

☐ Tissue Source: ☐ Other:

DATE COLLECTED (MM/DD/YYYY)	TIME COLLECTED (OO:OO AM/PM)	SPECIMEN ACCESSION NUMBER

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.

BIRTH DATE (MM/DD/YYYY)	ADDRESS

CITY	STATE	ZIP CODE

GENDER
☐ Female ☐ Male

ETHNICITY
☐ Hispanic ☐ Non Hispanic ☐ Unknown

RACE
☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown

PROVIDER INFORMATION

PROVIDER LAST NAME	PROVIDER FIRST NAME

PROVIDER FACILITY NAME	PROVIDER TELEPHONE NUMBER

ADDRESS	CITY	STATE	ZIP CODE

SUBMITTER INFORMATION (RESULTS ARE RETURNED TO THIS ADDRESS)

FACILITY NAME

ADDRESS	CITY	STATE	ZIP CODE

SUMBITTER CONTACT NAME	SUBMITTER TELEPHONE NUMBER

ADDITIONAL PATIENT INFORMATION

MEDICAL RECORD/CHART ID	PATIENT'S COUNTY OF RESIDENCE

Primary Insurance: ☐ MEDICAID ☐ MEDICARE ☐ TRICARE ☐ OTHER _____ MEMBER I.D. NUMBER:

ICD-10 Diagnosis Code (Required) Primary: _____ Secondary: _____ Additional: _____