



State of Washington
Department of Health
PUBLIC HEALTH LABORATORIES
1610 N.E. 150th Street
Shoreline, Washington 98155-9701
Phone: (206) 418-5473
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MTS #1327 CLIA #50D0661453

Lab Number _____ Date/Time Received _____

Please Print Clearly **MYCOBACTERIUM TUBERCULOSIS ISOLATES**

FOR PHL USE ONLY

PATIENT

NAME (LAST)		(FIRST)			(MIDDLE)		
ADDRESS				CITY		STATE	ZIP CODE
MALE	FEMALE	DATE OF BIRTH	MO	DAY	YR	COUNTY	CHART OR PATIENT ID NUMBER
<input type="radio"/>	<input type="radio"/>	/ /					

SPECIMEN

SUBMITTER		PRIMARY SUBMITTER	
ADDRESS		ADDRESS	
CITY		STATE	ZIP CODE
PERSON FILLING OUT FORM		PHONE NUMBER	
SPECIMEN SOURCE: <input type="radio"/> SPUTUM <input type="radio"/> GASTRIC <input type="radio"/> BLOOD <input type="radio"/> URINE <input type="radio"/> BRONCHIAL WASH <input type="radio"/> CSF <input type="radio"/> FLUID (SPECIFY) _____ <input type="radio"/> TISSUE (SPECIFY) _____ <input type="radio"/> WOUND (SITE) _____ <input type="radio"/> OTHER (SPECIFY) _____		COUNTY PHONE NUMBER PRIMARY PHYSICIAN PHONE NUMBER	
LABORATORY EXAMINATION REQUESTED: <input type="radio"/> ANTIMICROBIAL SUSCEPTIBILITY <input type="radio"/> STOCK <input type="radio"/> MTD <input type="radio"/> PZA <input type="radio"/> PLATE SENSI <input type="radio"/> RFLP <input type="radio"/> OTHER (SPECIFY) _____		SPECIMEN WAS RECEIVED AS: <input type="radio"/> REFERENCE ISOLATE <input type="radio"/> CLINICAL SPECIMEN	
SUSCEPTIBILITY RESULTS: (PLEASE CIRCLE) IHN S R STREP S R RIF S R EMB S R PZA S R OTHER(SPECIFY) _____ S R		HAVE SPECIMENS FROM THIS PATIENT BEEN SUBMITTED PREVIOUSLY? <input type="radio"/> YES <input type="radio"/> NO DATE COLLECTED MO DAY YR DATE RECEIVED MO DAY YR SMEAR RESULT AND DATE MO DAY YR POSITIVE NEGATIVE DATE POS MTB REPORTED MO DAY YR DATE SENSI REPORTED MO DAY YR DATE SENT TO STATE LAB MO DAY YR	

COMMENTS

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