Request form for smear microscopy and Xpert assays

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| **REQUEST** *(to be completed by the clinician)* | | | | | | | |
| **Sender information** | | | | | | | |
| Facility | | Address | | | | Date of requesta  / / | |
| Requested by (name and signature) | | | Phone | | Email | | |
| **Patient information** | | | | | | | |
| Name and surname | | | Age | Date of birtha  / / | | | Sex ☐ M ☐F |
| TB register N° b | | Address | | | | Phone | |
| **Clinical information** | | | | | | | |
| History of TB treatment: ☐ New case ☐ Previously treated ☐ Unknown If previously treated: ☐ For DS-TB ☐ For DR-TB  Outcome previous treatment: ☐ Failure ☐ Relapse ☐ Lost to follow-up ☐ Unknown | | | | | | | |
| **Specimen information** | | | | | | | |
| Type of specimen ☐ Sputum ☐ Other *(specify)*c: | | | | | | | |
| Date of collectiona: / / | | | Time of collection: | | | | |
| **Test requested** | | | | | | | |
| **Microscopy** | | | | | | | |
| * Diagnostic Specimen numberd: | | | * Follow-up Monthe: | | | | |
| * **Xpert MTB/RIF (or Ultra)** ☐ **Xpert MTB/XDR** | | | | | | | |
| * Diagnostic Specimen numberd: | | | * Other *(specify)*f: | | | | |
| **RESULTS** *(to be completed by the laboratory)* | | | | | | | |
| **Microscopy** | | | | | | | |
| Lab. register N° ☐ Ziehl-Neelsen ☐ Fluorescence  Visual appearanceg ☐ No AFB ☐ Scanty ☐ 1+ ☐ 2+ ☐ 3+  Exact number: | | | | | | | |
| Laboratory name: Date of examinationa: / / Examined by (name and signature): | | | | | | | |
| **Xpert MTB/RIF** | | | | | | | |
| Lab. register N° | MTB ☐ Detected ☐ Not detected ☐ Trace ☐ Inconclusiveh Résistance RIF ☐ Detected ☐ Not detected ☐ Indeterminate | | | | | | |
| **Xpert MTB/XDR** | | | | | | | |
| Lab. register N° | MTB ☐ Detected ☐ Not detected ☐ Inconclusiveh Low H resistance ☐ Detected ☐ Not detected ☐ Indeterminate H resistance ☐ Detected ☐ Not detected ☐ Indeterminate Low FQ resistance ☐ Detected ☐ Not detected ☐ Indeterminate FQ resistance ☐ Detected ☐ Not detected ☐ Indeterminate Amk resistance ☐ Detected ☐ Not detected ☐ Indeterminate Eto resistance ☐ Detected ☐ Not detected ☐ Indeterminate | | | | | | |
| Laboratory name: Date of examinationa: / / Examined by (name and signature): | | | | | | | |

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1. dd/mm/yyyy
2. For registered patients only (i.e. diagnosed and on treatment).
3. Cerebrospinal fluid (CSF), gastric aspirate (GA), stool (ST), fine needle aspirate (FNA), nasopharyngeal aspirate (NPA), etc.
4. 1 if first specimen, 2 if second specimen, etc.
5. 1 for the first month of treatment, 2 for the second month of treatment, etc.
6. Suspicion of emergence of a new resistance, etc.
7. Muco-purulent (M), blood stained (B), saliva (S).
8. Inconclusive results include: no result, invalid results, and error.

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