Request form for culture, pDST, LPA, genome sequencing

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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** | |
| **Culture** | |
| * Diagnostic Specimen numberd: | * Follow-up Monthe: |
| **pDST** | |
| * Diagnostic Specimen numberd: | * Follow-up Monthe: |
| Drugs ☐ First-line ☐ Lfx ☐ Mfx ☐ Bdq ☐ Lzd  ☐ Cfz ☐ Dlm ☐ ☐ ☐ | |
| **LPA** ☐ **First-line** ☐ **Second-line** | |
| * Diagnostic Specimen numberd: | * Other *(specify)*f: |
| **Genome sequencing** ☐ **Deeplex** ☐ **Other** *(specify)*: | |
| * Diagnostic Specimen numberd: | * Other *(specify)*f: |

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.

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