

Tuberculosis Test Request Form

Name (Last, First)		Lab ID			
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Patient Zip Code	Collection Date	DOB	MONTH DAY YEAR
<input type="checkbox"/> New Suspect <input type="checkbox"/> Routine Workup <input type="checkbox"/> Known Active Case		TYPE <input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> Other _____		TEST <input type="checkbox"/> AFB Smear and Culture <input type="checkbox"/> TB Culture Confirmation <input type="checkbox"/> AFB Identification <input type="checkbox"/> TB Susceptibility Testing <input type="checkbox"/> TB NAAT <input type="checkbox"/> TB MDDR <input type="checkbox"/> Other _____	
SEND REPORT TO Facility _____ Attention _____ Address _____ City/State/Zip _____ PHYSICIAN _____ Phone _____			 <p style="margin: 0;"> <small>IDAHO DEPARTMENT OF HEALTH & WELFARE</small> DIVISION OF PUBLIC HEALTH </p> <p style="margin: 0;"> Bureau of Laboratories 2220 Old Penitentiary Road Boise, Idaho 83712 (208) 334-2235 </p> <p style="margin: 0; font-size: small;">Revised 10/08/15</p>		