TB

BC Centre for Disease Control
Provincial Health Services Authority

Public Health Laboratory

655 West 12th Avenue, Vancouver, BC V5Z 4R4
www.bccdc.ca/publichealthlab

Mycobacteriology / TB Requisition

Highlighted fields must be completed

Section 1 - Patient/Provider Information *(Two matching unique patient identifiers on sample container and requisition are required for sample processing)*

PERSONAL HEALTH NUMBER (or out-of-province Health Number)	**PATIENT ADDRESS**		DATE RECEIVED
PATIENT LAST NAME			**LABORATORY USE ONLY**
PATIENT FIRST AND MIDDLE NAME	**CITY**	**PROVINCE**	
DOB DD / MMM / YYYY — **SEX** M ☐ F ☐ X ☐ Unk ☐	**POSTAL CODE**	**CONTACT NO.** (XXX) XXX-XXXX	
SAMPLE REF. NO.	**DATE COLLECTED** (DD/MMM/YYYY) Unk ☐	**TIME COLLECTED** (HH:MM) Unk ☐	

ORDERING PRACTITIONER (Name, MSP#, Address of report delivery)

☐ **I am a Locum** (provide name of Practitioner and Clinic to receive report)

ADDITIONAL COPIES TO PRACTITIONER / CLINIC: **(Limit of 3 copies available)**
(Name, Address / MSP#/ PHSA Client#)

1.

2.

3.

SIGNATURE OF ORDERING PRACTITIONER

DATE SIGNED

Section 2 - Test(s) Requested

SAMPLES FOR AFB SMEAR AND MYCOBACTERIUM CULTURE

Indicate sample type:

- ☐ Sputum (+) (Each sputum container should go into its own separate biohazard bag)
- ☐ Induced Sputum
- ☐ Bronchial wash
- ☐ Tissue, specify source: _____
- ☐ Bodily fluid, specify source: _____
- ☐ Gastric wash (please use only pre-made buffered glass jars from BCCDC)
- ☐ Urine
- ☐ Blood
- ☐ Feces
  - ☐ History of HIV infection
  - ☐ Suspect gastrointestinal TB infection
- ☐ Other sample, specify: _____

INTER-LABORATORY SAMPLES

Samples for Mycobacterium Nucleic Acid Testing:

Specify source: _____

Has sample been digested? ☐ Yes ☐ No

Has sample been concentrated? ☐ Yes ☐ No

Acid-fast smear result: _____

TB molecular result: _____

Rifampin molecular result: _____

Cultures of Mycobacterium:

Specify source: _____

Date culture became positive: _____

SPECIAL TEST REQUESTS*

*Consultation required, please call Medical Microbiologist On-Call at (604) 661-7033

_____

_____

EXPOSURE & TREATMENT HISTORY

- ☐ Exposure to active TB case
- ☐ Exposure to drug-resistant TB
  Specify country of exposure: _____
- ☐ Member of high-risk group
  Specify: _____
- ☐ Positive TB skin test or interferon-gamma release assay (IGRA)
- ☐ Currently on TB treatment

CLINICAL HISTORY

_____

_____

_____

_____

_____

_____

For other available tests and additional information, consult the Public Health Laboratory's *eLab Handbook* at www.elabhandbook.info/PHSA/Default.aspx

The personal information collected on this form is collected under the authority of the Personal Information Protection Act. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the Personal Information Protection Act and when applicable the Freedom of Information and Protection of Privacy Act and may be used and disclosed only as provided by those Acts.

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