MINISTRY OF HEALTH – MALAWI

NATIONAL TB & LEPROSY ELIMINATION PROGRAMME

TB LABORATORY REQUEST FORM VERSION 2 (2023)

Health Facility: _____ **Department/Ward:** _____

Patient's Full Name: _____ Age: _____ Gender: Male ☐ Female ☐

Village/Street: _____ District: _____ Telephone: _____

Reason for examination: Diagnosis ☐ Follow up ☐ If follow up: 2 months ☐ 5 months ☐ 6 months ☐ District TB Reg no. _____ HIV status: Positive ☐ Negative ☐ Unknown/Not tested ☐

TB treatment history: New ☐ Previously treated ☐

Source: OPD ☐ In patients/Wards ☐ community ☐ PPMx site ☐ TB clinic ☐ Under five ☐ Other please specify_____

Type of sample: Sputum ☐ Stool ☐ Other ☐ (specify) _____Date sample collected: _____Time of collection ..... **Recollection Due to Rejection?** ☐

Examination requested: Microscopy ☐ Slit-Skin Smear (SSS) ☐ Xpert Ultra☐ Trunat ☐ Urine LAM ☐ Other☐ Reflex Testing (XDR) ☐ Specify other test_____

Indications for Xpert Ultra or Xpert MTB/RIF:

Presumptive DR-TB	Hospitalized	HIV positive	Children	Prisoner	Minor/X-miner	Others (specify)
Indications for Urine Lam (*Strictly for HIV positive clients only*)		CD4<200	AHD (WHO) Stage 4	Critically Ill	Others (Specify)	

Name of requestor: _____Phone No..... Date of request: _____

Laboratory Results (*to be completed in the laboratory*)

Lab serial number: _____ Date sample(s) received: _____

Macroscopic examination: Muco-purulent ☐ Blood-stained ☐ Saliva ☐ other (specify) _____

Microscopy: Ziehl-Neelsen ☐ Fluorescence ☐

Date	Sputum Sample	Result	Positive (Grading)				Slit-Skin Smear Result	Examined by	
			3+	2+	1+	Actual number		Name	Signature
	1								
	2								

Xpert Ultra ☐ **Trunat** ☐

Date	Sample	Results									Test performed by (*name & signature*)
		MTB not detected	MTB detected	MTB detected Trace	RIF resistant not detected	RIF resistant detected	RIF resistant indeterminate/Trace	No result	Error	Invalid	

REFLEX TEST RESULT (XDR)				
DRUG		**Results**		**Test performed by** (*Name & signature*)
		Resistant	**Susceptible**	
Isoniazid				
Ethionamide				
Fluoroquinolones	Moxifloxacin			
	Levofloxacin			

URINE LAM

Date	Results	Test performed by (*Name & signature*)

Comment: _____

Results reviewed by _____ Signature_____ Date_____