FORM 2A. LABORATORY REQUEST AND RESULT FORM

To be filled out by Health Worker

Name of Requesting Facility/Unit: ___________________________ Date of Request: ________________
Facility Contact Information: ___________________________ Requesting Physician: ___________________________
Patient’s Full Name: ___________________________ Age: ________________ Sex: [ ] M [ ] F
Province/City: ___________________________ Patient’s Contact No.: ___________________________

Reason for Examination: [ ] Diagnosis [ ] Baseline [ ] Follow-up TB Case No.: ___________________________
History of Treatment: [ ] New [ ] Retreatment Month of treatment: ___________________________

Test Requested: [ ] Xpert MTB/RIF [ ] Smear Microscopy [ ] TB LAMP [ ] LPA [ ] 1st Line [ ] 2nd Line [ ] Culture [ ] DST

* Is Paragonimiasis considered? [ ] Yes [ ] No

Type of Specimen: [ ] Sputum Repeat Collection? [ ] No [ ] Yes, Reason: ___________________________
[ ] Other, Specify: ___________________________

Date: Specimen Date Collected Date Dispatched to Laboratory
1
2
Remarks: (i.e. pre-collection details; existing medical conditions, medications taken prior to screening, and/or known risk factors)

Prepared by: ___________________________ Designation: ___________________________
Signature over Printed Name

To be filled-out by Medical Technologist/Microscopist/Xpert Technician

Name of Laboratory: ___________________________
Specimen Received by: ___________________________ Date and Time Specimen Received: ___________________________
Specimen Volume and Quality: ___________________________ [ ] Accepted [ ] Rejected, reason: ___________________________
Laboratory Serial Number: ___________________________ Date Specimen Examined: ___________________________

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<th>DIAGNOSTIC TESTS</th>
<th>RESULTS</th>
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<tr>
<td>[ ] Xpert MTB/RIF</td>
<td>[ ] Xpert MTB/RIF Ultra</td>
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<tr>
<td>Smear Microscopy</td>
<td>Paragonimiasis* 1 2</td>
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<td>TB Reading</td>
<td>1 2**</td>
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<td>Laboratory Diagnosis</td>
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* Results for Paragonimiasis: P – if Paragonimus ova only are seen, T – if AFB only are seen, Co-l – if BOTH ova and bacilli are seen, Neg – No ova and No bacilli are seen
** Specimen 2 is not applicable for follow-up

Performed by: ___________________________ Verified by: ___________________________ Noted by: ___________________________
Signature over Printed Name Signature over Printed Name Signature over Printed Name

Date and Time Released: ___________________________ A separate result form for LPA, Culture, and DST will be issued.

Form 2a. Laboratory Request and Result Form
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