FORM 2D. TB CULTURE RESULT FORM

TB Case Number: _____ Date of Request: _____

Name of Requesting Facility/Unit: _____ Requesting Physician: _____

Patient' Full Name: _____ Name of Laboratory: _____

Age: _____ Sex: [ ] M [ ] F

Reason for Examination: [ ] Baseline [ ] Follow-up; month: _____ [ ] Diagnosis

Type of Specimen: [ ] Sputum [ ] Others (specify): _____

Method: [ ] Solid Culture [ ] Liquid Culture: MGIT

	TB Culture Laboratory Number	Date Specimen Collected	Date and Time Specimen Received	TB Culture Result
1				
2				

Remarks: _____ Date and Time Released: _____

Performed by: Verified by: Noted by:

_____ _____ _____

Signature over Printed Name *Signature over Printed Name* *Signature over Printed Name*