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

<table>
<thead>
<tr>
<th>TB Culture Laboratory Number</th>
<th>Date Specimen Collected</th>
<th>Date and Time Specimen Received</th>
<th>TB Culture Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>2</td>
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Remarks: ___________________________________________________  Date and Time Released: ___________________________

Performed by: ___________________________  Verified by: ___________________________  Noted by: ___________________________

_________________________  ___________________________  ___________________________
Signature over Printed Name  Signature over Printed Name  Signature over Printed Name