# Laboratory request form

(one specimen per sheet)

**National Reference Center for Mycobacteria**
Research Center Borstel
Leibniz Lung Center
Parkallee 38, 23845 Borstel
Germany

**Diagnostic mycobacteriology**
Dres. med. Friesen/Kuhns
Phone: +49 4537 / 188 - 2110
Fax: +49 4537 / 188 - 3110
Email: nrz@fz-borstel.de

NRZ number

Reset

| **Patient data** | | | | **Referring institution** | |
|---|---|---|---|---|---|
| **Surname** | | | | **Name** | |
| **First name** | | | | **Address** | |
| **Street** | | | | | |
| **Postal code / City** | | | | | |
| **Country** | | | | | |
| **Date of birth** | | **Sex** | ☐ m ☐ w | **Phone** | |
| **Date of shipment** | | **Sampling date** | | **Fax** | |

**Clinical and diagnostic information**

☐ Cystic fibrosis ☐ HIV ☐ Immunosuppression ☐ Antibiotic treatment with: _____
☐ Probable TB ☐ Probable MDR ☐ Probable NTM
☐ Known TB ☐ Known RMP resistance ☐ Known INH resistance
☐ Follow up TB ☐ TB treatment since _____ with: _____

Result of differentiation (if available): _____

**Comments:**

**Specimen**

Laboratory number of referring laboratory _____

☐ primary material ☐ liquid culture ☐ solid culture
☐ sediment* ☐ DNA* ☐ paraffin embedded material*
*primary material is preferred

| **Non sterile** | | **Sterile** | | |
|---|---|---|---|---|
| ☐ Sputum | ☐ Skin biopsy* | ☐ Blood | ☐ Pleural fluid | ☐ Pus* |
| ☐ Bronchial secretion | ☐ Urine (morning urine) | ☐ Bone marrow | ☐ Pleural biopsy | ☐ Abscess aspirate* |
| ☐ BAL | ☐ Menstrual blood | ☐ Liquor | ☐ Pericardial fluid | ☐ Other* |
| ☐ Protected brush | ☐ Stool | ☐ EBUS (biopsy) | ☐ Pericardial biopsy | |
| ☐ Gastric fluid | ☐ Swab **(not suitable)** | ☐ Lymph node* | ☐ Joint aspirate | ☐ Swab **(not suitable)** |
| ☐ Gastric lavage | | ☐ Tissue biopsy* | ☐ Aspirate | |

*Location of biopsy: _____

**Requested investigation - primary material / DNA / paraffin embedded material**

☐ Culture
☐ NAT (MTBC and RMP) ☐ NAT (NTM) ☐ NAT (RMP, INH) ☐ NAT (fluoroquinolones, injectible drugs) ☐ Other: _____

**Requested investigation - solid / liquid culture**

☐ Identification ☐ Identification, phenotypic and genotypic DST* (if needed) ☐ First-line phenotypic and genotypic DST ☐ NTM DST
☐ Extended DST for INH resistant isolate ☐ Second-line phenotypic and genotypic DST
☐ DST for the following drugs: _____
☐ NAT (RMP, INH) ☐ NAT (fluoroquinolones, injectable drugs) ☐ Other: _____
☐ Typing and comparison of patient isolates, please specify: _____
*DST=drug susceptibility testing

| **Billing address** | **Additional recipient** |
|---|---|
| ☐ Billing address identical with sender | |

0102