

Laboratory request form

(one specimen per sheet)

National Reference Center for Mycobacteria
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 Leibniz Lung Center
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Diagnostic mycobacteriology
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**NRZ
number**

Patient data				Referring institution	
Surname				Name	
First name				Address	
Street					
Postal code / City					
Country					
Date of birth		Sex	<input type="checkbox"/> m <input type="checkbox"/> 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
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<input type="checkbox"/> Sputum <input type="checkbox"/> Skin biopsy* <input type="checkbox"/> Bronchial secretion <input type="checkbox"/> Urine (morning urine) <input type="checkbox"/> BAL <input type="checkbox"/> Menstrual blood <input type="checkbox"/> Protected brush <input type="checkbox"/> Stool <input type="checkbox"/> Gastric fluid <input type="checkbox"/> Swab (not suitable) <input type="checkbox"/> Gastric lavage	<input type="checkbox"/> Blood <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Pus* <input type="checkbox"/> Bone marrow <input type="checkbox"/> Pleural biopsy <input type="checkbox"/> Abscess aspirate* <input type="checkbox"/> Liquor <input type="checkbox"/> Pericardial fluid <input type="checkbox"/> Other* <input type="checkbox"/> EBUS (biopsy) <input type="checkbox"/> Pericardial biopsy <input type="checkbox"/> Lymph node* <input type="checkbox"/> Joint aspirate <input type="checkbox"/> Swab (not suitable) <input type="checkbox"/> Tissue biopsy* <input type="checkbox"/> Aspirate
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*Location of biopsy: _____

Requested investigation - primary material / DNA / paraffin embedded material

Culture
 NAT (MTBC and RMP) NAT (NTM) NAT (RMP, INH) NAT (fluoroquinolones, injectable 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
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<input type="checkbox"/> Billing address identical with sender	
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