

TB Screening by EIA

For lab use only

Specimen Collection Information

Date of Collection ____/____/____

Time Drawn ____:____ AM PM

Tubes Mixed 10 times after Collection:

Yes No

Tube Incubation Start Time:

____:____ AM PM

Date Incubation Start: _____

Tube Incubation End Time:

____:____ AM PM

Date Incubation End: _____

Did tube remain upright during entire incubation? Yes No

MR # _____ ID # _____

Name _____

Address _____

City/State _____

Zip Code _____

Phone _____ Sex/Race ____ DOB __/__/__

SS # ____-____-_____

Submitted by _____

Address _____

County/Clinic _____

Program _____

Mississippi Public Health Laboratories
Main Lab - 570 East Woodrow Wilson
Jackson, Mississippi 39216
Phone - 601-576-7582

Lawson Street Lab - 3152 Lawson Street
Jackson, Mississippi 39213
Phone - 601-981-6158

Mississippi State Department of Health FORM 493 (REVISED January 2015)

Place Barcode Label
Here.

TB Screening by EIA, REQ-493 Instructions

PURPOSE:

1. To collect demographic information on patient's screened for tuberculosis infection by the EIA method.
2. To collect information on the collection and handling of sample tubes between collection and receipt by the laboratory.

GENERAL:

The form is divided into 3 sections. The left third is for laboratory use only and should be left blank.

The right section is for patient and submitter information. The patient's name, address and zip code should be legibly entered. MSDH PIMS labels can be substituted here as with other lab request forms. The patient's date of birth should be entered in the appropriate blank. All submitters must fill in the blank provided for the ordering physician. Lab testing cannot be done without a doctor's order. The contact name and phone number are for reporting purposes.

Place Mississippi State Department of Health (MSDH) Patient Information Management System (PIMS) information label or non MDH patient information label over demographic area containing patient's name, address, city, state, zip code, date of birth, sex, race, Social Security Number, and Clinic Name.

Note: Please attach MSDH PIMS or non MSDH provider labels to both copies

If label with patient demographic information is unavailable, please complete each line with applicable information.

All written information must be legible.

MR # - Enter patient's medical records number if available.

ID # - Enter patient's PIMS number if available.

- **Name** - Enter the patient's LAST NAME, FIRST NAME, AND MIDDLE INITIAL in sequence. The spelling of the name on the laboratory slip and the specimen container/tube must be identical.
- **Street Address** - Enter the complete address where the patient currently lives. Post Office Box number. Should only be accepted as if physical address is not available.
- **City** - Enter the name of the city in which the patient lives.
- **State** - Enter the state in which the patient lives.
- **Zip Code** - Enter the Zip Code of the patient's address.
- **Phone #** - Enter telephone number including area code if available.
- **Sex** - Enter "M" in space for male and "F" in space for female.
- **Race** - Enter the patient's race in the space provided (White, Asian, Black, Native American, Hawaiian/Pacific Islander, or other).

- **DOB** - Enter the Date of Birth (month, day, and year) of patient in the space provided.
- **Social Security Number** - Enter patient's nine digit Social Security Number in the spaces provided.
- **Submitted by** - Enter the name of the clinic/submitter in the space provided.
- **Address** – Enter the address of the clinic/submitter.
- **County/Clinic** – Enter the name of the county for the clinic/submitter.
- **Program**- Enter the name of the program requiring testing.

The middle section is for Specimen collection information. Please note that it is **required** that all of the **Specimen Collection Information** blanks be filled in. It is important that these blanks are filled in to ensure proper test results.

- **Date of Collection**- Enter the date the specimen was drawn
- **Collection Time**- Enter the time the specimen was drawn, mark the appropriate AM/PM box
- **Were tubes mixed 10 times after collection?**- check appropriate box
- **Tube incubation start time**: Enter the time the tubes were placed in the 37°C incubator, check the appropriate AM/PM box
- **Tube incubation start date**: Enter the date the tubes were placed in the 37°C incubator
- **Tube incubation End Time**:- Enter the time the tubes were removed from the 37°C incubator, check the appropriate AM/PM box
- **Tube incubation end date**: Enter the date the tubes were removed from the 37°C incubator
- **Did the tubes remain upright during the entire incubation?** Mark the appropriate box.

Bar Code Label:

The laboratory will use this area to place a bar code sticker

OFFICE MECHANICS AND FILING

This form should be completed each time a QuantiFeron (TB EIA) is collected and should accompany the specimen to the Mississippi State Department of Health Laboratory. Once test results are obtained, the white copy will be retained by the lab, an electronic copy of the results will be returned to the submitting health department/clinic to be placed in the client's medical record. Laboratory reports are kept for a minimum of 2 years as CLIA regulations require.

RETENTION PERIOD

The county health department/clinic must retain a copy of the form along with the client's chart according to agency policy. Lab slips become a part of the employee's permanent file.