Mycobacteriology Culture Request

For Lab Use Only

❑ Unsatisfactory Specimen
❑ Name on specimen and form do not agree
❑ No name on specimen
❑ Leaked in transit
❑ QNS: results unreliable
❑ Other ____________

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

Specimen source: Check all that apply.

❑ Sputum
❑ Sputum induced
❑ Bronchial specimen
❑ CSF
❑ Pleural fluid
❑ Urine
❑ Synovial fluid
❑ Pericardial fluid
❑ Ascites
❑ Lung tissue
❑ Lymph node
❑ Reference Culture (Pure Isolate) Media _________ Source __________________
❑ Other ___________
❑ Concentrated specimen source ____________

Digestion method: ❑ NALC ❑ Other ___________________

Submitter smear result: ❑ Negative ❑ 1+ ❑ 2+ ❑ 3+ ❑ 4+

❑ Request MTB-RIF (PCR) Date smear result reported ___/___/___

Date Collected ___/___/___

MR # _________________ ID # ______________________
Name ____
Address ____
Sex/Race _____________ DOB ____/_____/ ___________
SS # _________-______-__________
Submitted by _____________________________________
Address ____
Phone ____
County/Clinic ____________________________________
Program ____

Requesting physician ______________________________

Currently receiving anti-tuberculosis therapy? ❑ Yes ❑ No

How long? _________________________

Previous history of TB _____________________________

Place Barcode Label Here.

Mississippi State Department of Health FORM 416 (REVISED June 2017)

Mycobacteriology Culture Request Requisition 416 Instructions

PURPOSE

To request laboratory testing of specimens for smear and culture of *Mycobacteria tuberculosis*; to document results of laboratory testing of such specimens.

INSTRUCTIONS

Identifying data - The following may be written in black ink, stamped using the embosser card, or printed on computer label and attached in the space provided.

MR # - Enter the patient's medical records number.

ID # - Enter the patient's PIMS number if applicable.

Name- Enter the last name, first name, and middle initial of the patient.

Address - Enter the patient's complete mailing address including city and zip code.

Sex - Enter sex of patient.

Race - Enter the race of the patient.

DOB-MM/DD/YY - Enter the patient's full date of birth, including month, day, and year.

Social Security # - Eater the patient's Social Security number.

Submitted by - Enter the name of the clinic/submitter in the space provided.

Address – Enter the address of the clinic/submitter.

Phone – Enter the phone number for the clinic/submitter.

County/Clinic – Enter the name of the county for the clinic/submitter.

Program – Enter the type of clinic or services the patient is provided.

Requesting Physician - Enter the name of patient's physician.

Currently receiving anti-tuberculosis therapy – check YES if patient is currently receiving medication for tuberculosis, otherwise check NO.

How long? – Enter the number of days/months that patient has been receiving anti-tuberculosis therapy.

Previous history of TB – If patient has a prior history of tuberculosis, write date of diagnosis. Do not include previous history of Mycobacteria other than tuberculosis.

Specimen source – Check the box for the type specimen collected. Reference culture – enter type of media and specimen source.

Digestion method – If NALC digestion method not used, check other and indicate method used.

Submitter smear result – Check appropriate box for smear result.

Date smear reported – Indicate date smear result reported

Request MTB-RIF (PCR) – Check box if MTB-RIF PCR is requested. MTB-RIF is only performed on respiratory specimens from patients that have not been on anti-tuberculosis therapy or who have received less than 3 days of therapy.

Date Collected - Enter the month, day, and year in which the specimen was collected
The left side of the form is for laboratory use only.

OFFICE MECHANICS AND FILING

The top copy (white) should accompany the specimen to the MSDH Laboratory. The bottom copy (yellow) should be maintained by the submitter which collected the specimen as a receipt of testing.

Once the test results are determined and entered into the Laboratory Information Management System (LIMS), the results will be printed and forwarded to the appropriate submitter (clinic). Critical values will be telephoned and faxed as soon as they are determined.

The top copy will be retained by the MDH Laboratory in accordance with Clinical Laboratory Improvement Amendments (CLIA) regulations. The submitter of the specimen will file the LIMS copy of the results in the patient's record.

RETENTION

All clinical laboratory test records are retained for a minimum of 2 years.
The county health department/clinic may retain a copy of the form in the patient's medical record according to agency policy.