# NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE PROGRAM

## DRUG RESISTANCE TB LABORATORY INVESTIGATION REQUEST FORM

**COUNTY: ____________________________________/** **SUB COUNTY: _______________________________________/** **FACILITY NAME: _______________________________________/**

<table>
<thead>
<tr>
<th>PATIENT IDENTIFICATION:</th>
<th>CONTACT INFORMATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Clinicians Name:</td>
</tr>
<tr>
<td>TB Registration No./IP/OP No:</td>
<td>Clinician Email:</td>
</tr>
<tr>
<td>DOB/Age:</td>
<td>Sub County TLC name:</td>
</tr>
<tr>
<td>Sex:</td>
<td>Telephone No:</td>
</tr>
<tr>
<td>Telephone No:</td>
<td>Sub County TLC email:</td>
</tr>
</tbody>
</table>

**Signature:**  

(Indicate/Tick as appropriate)

- Baseline test:  
- Follow up Investigation:  
- Month of treatment:  

**Month:** ____________

### SPECIMEN COLLECTION DETAILS

- Date: _______/______/_______  
- Time collected: ____________  
- Collected by: ____________

### SPECIMEN TYPE (Indicate by ticking)

- [ ] Blood  
- [ ] Others (Specify)

### TEST REQUESTED (Indicate by Ticking)

- [ ] Full Blood Count  
- [ ] LFTs (AST, ALT, Bilirubin)  
- [ ] Serum Albumin  
- [ ] Creatinine  
- [ ] Potassium  
- [ ] Others (Specify)  
- [ ] TSH  
- [ ] Magnesium  
- [ ] Others (Specify)  
- [ ] Lipase  
- [ ] Calcium  
- [ ] Amylase  
- [ ] Hepatitis B and C  

**Lab receipt:**

- [ ] Purple top  
- [ ] Red/Yellow top  
- [ ] Cryovial

**Received by:** ___________________________  
**Time:** ___________________________  
**Date:** ___________________________