NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE PROGRAM

XPERTMTB/RIF & SPUTUM SMEAR EXAMINATION REQUEST FORM

Patient Name (3 names): ...........................................................................................................Age: ..................................Sex: .......................

Patient’s Mobile No: ..................................Physical address: .................................. Guardians mobile No:........................................

OP/IP Patient ID: .................................. MDRTB Register No: .................................. TB register No: ..................................

Ward/Department: .................................. Facility: ..................................County: .................................. Sub County: ..................................

Clinician/HCW Mobile No: .................................. Email: .................................. Signature: ..................................

SCTLC’s Mobile: .................................. Email: ..................................

CTLc Mobile No: .................................. Email: ..................................

Date of sample collection: ........................................................................................................

HIV Status: Positive O Negative O Not done O Declined O

Reasons for smear examination: (Tick)
New O Follow up at 2 months O 4 Months O 6 months O Others specify: ..................................

Reasons for Xpert MTB/RIF testing (See the various indications and tick corresponding box)

1. Low risk for DR TB
All presumptive TB cases who are not in the high risk group
Including:
O PLHIV with TB symptoms
O Children <15 years with TB symptoms
O All presumptive Tuberculosis cases with a negative
Smear microscopy result

2. Cont’d Surveillance
O Smear positive at month 2 and 5 of TB treatment
O Patient who develops TB symptoms while on IPT or has had previous IPT exposure
O Healthcare workers with TB symptoms
O Prisoners with TB symptoms
O Refugees with TB symptoms

Type of sample: O Pulmonary (Sputum) O Extra pulmonary (specify)...........................................................

LAB REPORT
Date ........................................Time Sample received........ Method used: ZN FM Xpert

<table>
<thead>
<tr>
<th>Lab serial no.</th>
<th>Specimen type</th>
<th>Visual Appearance</th>
<th>Results</th>
<th>Xpert results**</th>
<th>Date &amp; Time dispatched</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Neg</td>
<td>Actual no.</td>
<td>+</td>
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</table>

**select one of the following
TS MTB detected Rif resistance not detected,
RR MTB detected & Rif resistance detected,
TI MTB detected Rif resistance indeterminate,
N MTB not detected
I Invalid/No results/Error

Examined by (Name and Signature)........................................Date____/________/________

Reviewed by (Name and signature) ........................................... Date____/________/________