REPUBLIC OF KENYA

MINISTRY OF HEALTH

NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE PROGRAM

DRUG RESISTANCE TB LABORATORY INVESTIGATION REQUEST FORM

COUNTY………………..………………..……..SUB COUNTY…………….............................. FACILITY NAME:…………………………………………

PATIENT IDENTIFICATION:	CONTACT INFORMATION:
Name:……………………………………………………………….	Clinicians Name:……………………………………………………….
TB Registration No./IP/OP No:…………………………..	Clinician Email:……………………………………………………….……
DOB/Age: …………………………………………………….	Sub County TLC name:…………………………………………….….
Sex: ……………………………………………………………….	Telephone No: : ……………………..……………………………….
Telephone No:………………………………………………	Sub County TLC email:………………………………………….…..
	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	
☐ Lipase	☐ Calcium	
☐ Amylase	☐ Hepatitis B and C	

Lab receipt:

☐ Purple top ☐ Red/Yellow top ☐ Cryovial

Received by: Time: ……………………………………………….. Date: ………………………………………………….