SHIP TO: ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Mycobacteriology Laboratory
2121 West Taylor,
Chicago, Illinois 60612
Phone number: 312-793-1063
Fax number: 312-793-7764

Mycobacteriology Laboratory Submission Form

Submitter Information

Authorization Number:	Submitter Code:
Submitter Phone #:	Submitter Fax #:
Submitting Hospital/Clinic/Laboratory Name:	
Submitter Mailing Address:	
City:	State:	Zip code:
Physician Name:	

Patient Information

Patient Name (First, Middle, Last):			Date of Birth:
Patient Address:			Patient Phone Number:
City:	State:	Zip code:	Medicaid Recipient ID:
Sex: Male Female	Ethnicity:		
Race:	Other Race Specify:		

Test Request Information

Specimen Collection Date:	Specimen Collection Time:
Specimen Source:	Specify:

Patient Clinical and Travel Information

Is the patient symptomatic? Yes No	Is patient a TB suspect? Yes No
Chest X-ray Result:	Date of Chest X-ray:

SMEAR, MOLECULAR, CULTURE,GROWTH DETECTION AND ISOLATE IDENTIFICATION		
AFB1	**Acid-fast Bacilli (AFB) Smear, Culture & Identification. NAAT (Respiratory specimen only) on first specimen smear positive or by request for subsequent specimen and negative smear. If culture positive for MTB, MTB1 will be performed.**	
AFB2	NAAT *(Respiratory specimen only)	***Has sample been digested? Yes No** ***Acid fast smear result:**
AFB3	Acid-fast Bacilli (AFB) Culture Identification. If culture positive for MTB, MTB1 will be performed for all new patients. **Isolate Submission Medium, Specify:**	
Other	Specify Other:	
Comment:		

ANTIMICROBIAL SUSCEPTIBILITY TESTING (AST) FOR MTB COMPLEX	
MTB1	First-Line Drugs: isoniazid 0.1, isoniazid 0.4, rifampin, ethambutol & pyrazinamide. MTB2 will be performed for all new patients
MTB2	Genotyping only. **Isolate Submission Medium, Specify:**
Other	Specify Other:
Comment:	

Epi Comment:

Mycobacteriology Laboratory Submission Form Instructions

This form should accompany all specimens to be submitted to the IDPH Mycobacteriology Laboratory. This form should be filled in electronically before printing. Fields with red outline are required and should be entered.

SUBMITTER INFORMATION:
Authorization Number – this number is what is generated through the IDPH WebPortal. Requests are entered by the local TB control authority. Required.
Submitter Code – this is facility-specific. Please contact the IDPH laboratory if you have questions on your facility's submitter code.
Submitter phone number, fax #, organization's name, and mailing address are required. The submitter is the originating facility or laboratory. Submitter information is required. Results are reported to TB control authorities and the submitting facility.
Physician name – the name of the ordering physician.

PATIENT INFORMATION:
Patient's name – required, please follow the first, middle, last name format.
Date of birth – the patient's date of birth is required
Patient's address, Patient's phone number, Medicaid recipient ID – are important information in case of positive results for TB. Laboratories are required, by law, to report suspect TB cases within 24 hours.
Sex – click one of the radio buttons.
Ethnicity – click on the arrow to reveal the dropdown options.
Race – click on the arrow to reveal the dropdown options.
Other – specify if the answer to the race field is "other."

TEST REQUEST INFORMATION:
Specimen collection date – required
Specimen collection time – important when doing serial sampling for release from isolation.
Specimen source – required.
Specify – can be used when the answer to the specimen source question is one of the following: "tissue," "body fluid," or "other."

PATIENT CLINICAL AND TRAVEL INFORMATION:
Is the patient symptomatic? – choose one of the radio buttons on whether the patient exhibits symptoms of tuberculosis
Is patient a TB suspect? – pertains to clinical suspicion for TB and is essential for infection control for laboratory personnel. Choose one of the radio buttons.
Chest x-ray result – essential for infection control and urgency of testing result reporting. Choose from the dropdown choices.
Date of chest x-ray – please enter the date of the chest x-ray that was resulted in the previous field.

SMEAR, MOLECULAR, CULTURE, GROWTH DETECTION AND ISOLATE IDENTIFICATION
May mark more than one request
AFB1 – includes AFB smear, culture, and identification. If the specimen is respiratory, NAAT will be performed on the first smear positive specimen. All culture positive specimens will be tested for antimicrobial susceptibility and genotyping. Additional testing will require approval from the IDPH TB program.
AFB2 – only NAAT will be performed. Only respiratory specimens will be allowed to choose this request. There is no need to request this if AFB1 is already requested. Please respond to whether the sample has been digested in the process of preparation from outside laboratory and if there are acid fast results available.
AFB3 – likely from outside laboratory. This request is for culture identification of AFB (+) specimens. All culture positive specimens will be tested for antimicrobial susceptibility and genotyping. Please specify the isolate submission medium,
Other, specify – additional testing on TB specimens are subject to approval by the IDPH TB program.

ANTIMICROBIAL SUSCEPTIBILITY TEST (AST) FOR MTB COMPLEX
MTB1 – Test for drug susceptibility to Isoniazid, rifampin, ethambutol, and pyrazinamide. Genotyping will be performed for all new patients.
MTB 2 – specimen will be sent for genotyping. Please specify the isolate submission medium.
OTHER, SPECIFY - additional testing on TB specimens are subject to approval by the IDPH TB program.

Please contact the IDPH TB program for additional help in filling out this form. Contact the IDPH Mycobacteriology Laboratory to request collection kit for TB samples or for shipping and specimen handling questions:
Phone number – 312-793-1063
Fax number – 312-793-7764