

TUBERCULOSIS

Name (Last, First)			Lab No.			
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Patient Zip Code:	Collection Date	MO DAY YEAR DOB		
<input type="checkbox"/> New Suspect <input type="checkbox"/> Routine Workup <input type="checkbox"/> Known Active Case		TYPE <input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> Urine <input type="checkbox"/> Other _____		TEST <input type="checkbox"/> Routine AFB Culture <input type="checkbox"/> TB Drug Sensitivity Testing <input type="checkbox"/> AFB smear only <input type="checkbox"/> Other _____		
SEND REPORT TO Facility _____ Attention _____ Address _____ City/State/Zip _____ PHYSICIAN _____ Phone: _____			State of Idaho DEPARTMENT OF HEALTH & WELFARE Bureau of Laboratories 2220 Old Penitentiary Road Boise, Idaho 83712			