RNTCP Request Form for examination of biological specimen for TB

(Required for Diagnosis of TB, Drug susceptibility Testing and follow up)

Patient Information			
Patient name		**Age (in yrs):____**	**Gender:** ☐M ☐F ☐TG
Patient mobile no. or other contact no.		**Specimen collection date** (DD/MM/YY) ________	☐ **Sputum** ☐ **Other (specify)______**
Aadhaar no.(If available)			
Patient address with landmark		**HIV Status:** ☐Reactive ☐Non-Reactive ☐Unknown	
		Key populations: ☐Contact of known TB Patient ☐Contact of known DR TB Patient ☐Diabetes ☐Tobacco ☐Prison ☐Miner ☐Migrant ☐Refugee ☐ Urban slum ☐Health-care worker ☐Other(specify) ______	

Name and Type of referring facility (PHI/DMC/TU/ DTC/ICTC/ART/Medical College/DR-TB Centre/RBSK/Private Others, specify): _______________________ **Health Establishment ID (NIKSHAY):** _ _ _ _	Type of patient: ☐ Public sector ☐ Private sector Episode ID: _______________
State: ____________________ **District:** ______________ **Tuberculosis Unit (TU):** _______________	

Reason for Testing

Diagnosis and follow up of TB		
Diagnosis of TB (for presumptive TB)		Follow up (Smear and culture)
H/O anti TB Rx for >1 month: ☐ Yes ☐ No		Reason: ☐ End IP ☐ End CP
☐ TB symptomatic ☐ Any abnormality in X-ray ☐ Repeat Exam ☐ Presumptive NTM	Predominant symptom _____________ Duration: ___days	Post treatment: ☐ 6m ☐ 12m ☐ 18m ☐ 24m

Diagnosis and follow up Drug-resistant TB		
Diagnosis of DR TB (DRT/ DST)		Follow up (Smear & culture)
Presumptive MDR TB	☐ New ☐ Previously treated	Treatment follow up month: _____ Type of case: ☐ H mono/poly TB ☐ MDR/RR TB ☐ XDR TB
	☐ At TB diagnosis ☐ Follow up Sm+ve DS TB	Regimen Type: ☐ All oral H mono/poly TB regimen ☐ Shorter MDR TB regimen ☐ All oral longer regimen ☐ Any other regimen ___________________________
☐ Presumptive H mono/poly		
Presumptive XDR TB	☐ MDR/RR TB at Diagnosis ☐ Failure of MDR/RR TB regimen ☐ Recurrent case of second line treatment	Regimen composition: ☐ Lfx ☐ Mfx^h ☐ Bdq ☐ Lzd ☐ Cfz ☐ Cs ☐ Z ☐ E ☐ Eto ☐ Dlm ☐ Am ☐ Km ☐ Cm ☐ _____

Test requested:

☐ Microscopy ☐TST ☐IGRA ☐Chest X-ray ☐Cytopathology ☐Histopathology ☐ CBNAAT ☐ TruNAAT ☐ Culture ☐DST ☐FL -LPA ☐SL -LPA ☐Gene Sequencing ☐Other (Please Specify) ________________

Requested by (Contact No. & Designation and Signature): ____
Contact Number:________________ Email ID:______________________

Results:

Microscopy (☐ ZN ☐ Florescent) Test ID: _______________							
	Lab Sr. No	Visual appearance	Result				
			Negative	Scanty	1+	2+	3+
Sample A		S M B					
Sample B		S M B					

Date tested: ______________ **Date Reported:** _______________ **Reported by:**____________________
Laboratory Name: ________________________________ **(Name and Signature)**

Date of specimen received: ____________________

Nucleic Acid Amplification Test (NAAT)	Lab serial _________ Test ID: _______________			
Type of test	☐ CBNAAT	☐ TrueNat		
Sample	☐ A	☐ B		
M. Tuberculosis	☐ Detected	☐ Not Detected	☐ N/A	
Rif Resistance	☐ Detected	☐ Not Detected	☐ Indeterminate	☐ N/A
Test	☐ No Result ☐ Invalid	☐ Error – Error Code________ (Please arrange for fresh sample)		

Date tested: ______________ **Date Reported:** _______________ **Reported by:** _____________________
Laboratory Name: ________________________________ **(Name and Signature)**

Culture (☐ LJ ☐ LC) Test ID: _______________				
Lab Sr. No	Negative	Positive	NTM (write species)	Contamination

Date Result: ______________ **Date Reported:** _______________ **Reported by:**_____________________
Laboratory Name: ________________________________ **(Name and Signature)**

First line LPA Lab serial _________ Test ID: _______________

☐ Direct ☐ Indirect ☐ Valid ☐ Invalid ☐ MTB detected ☐MTB not detected

Drug	**Resistant detected**	**Final interpretation**	**Remark**
Rifampicin (R)	☐ Yes ☐ Inferred ☐ No	If yes or inferred, R should not be given	
Isoniazid (Kat G)	☐ Yes ☐ Inferred ☐ No	If yes or inferred, H(h) should not be given	
Isoniazid (Inh A)	☐ Yes ☐ Inferred ☐ No	If yes or inferred, H(h) can be considered & Eto should not be given	

Date Result: ______________ **Date Reported:** _______________ **Reported by:** ___________________
Laboratory Name: ______________________________ **(Name and Signature)**

Second line LPA Lab serial _________ Test ID: _______________

☐ Direct ☐ Indirect ☐ Valid ☐ Invalid ☐ MTB detected ☐MTB not detected

Drug	**Resistant detected**	**Final interpretation**	**Remark**
Levofloxacin	☐ Yes ☐ Inferred ☐ No	If yes or inferred, Lfx should not be given. Mfx (h) can be considered.	
Moxifloxacin (h)	☐ Yes ☐ No	If yes, Lfx & Mfx (h) should not be given	
Amikacin	☐ Yes ☐ Inferred ☐ No	If yes or inferred, Am should not be given	
Kanamycin	☐ Yes ☐ Inferred ☐ No	If yes or inferred, Km should not be given	
Capreomycin	☐ Yes ☐ Inferred ☐ No	If yes or inferred, Cm should not be given	

Date Result: ______________ **Date Reported:** _______________ **Reported by:** _____________________
Laboratory Name: ______________________________ **(Name and Signature)**

Drug Susceptibility Test (DST) results Test ID: ___________

Lab Sr.No	1st line drugs					SLI				FQ				Other										
	R	H (0.1)	H (0.4)	Z	E	S	Km	Cm	Am	Lfx	Mfx (0.5)	Mfx (1.0)	Mfx (2.0)	PAS	Lzd	Cfz	Bdq	Dlm	Eto	Cs	Clr	Azi		

Date Result: ______________ **Date Reported:**_______________ **Reported by:**_____________________
Laboratory Name: ______________________________ **(Name and Signature)**
R: Resistant; S: Susceptible; C: Contaminated; -- Not done

Other tests for TB diagnosis Test ID: _______________

Test (Please Specify): ______________________
Result:____
Date reported: _______________ **Reported by:**_______________________
Laboratory Name: _____________________________ **(Name and Signature)**