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| **Logo  Description automatically generated** | **Massachusetts State Public Health Laboratory**  **305 South St, Jamaica Plain, MA 02130 - 3597**  CLIA # 22D0650270  **MYCOBACTERIOLOGY SPECIMEN SUBMISSION FORM** |

**PRINT, LABEL OR STAMP: *COMPLETE ONE FORM PER SPECIMEN***

MA SPHL

USE

ONLY

Submitting Site Patient Label

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| 1. **Submitting Facility (Receives Test Result):**   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Facility / Laboratory Name (*required)*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street Address  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City, State Zip  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone # (must be the # for result notification) Secure Fax #: | **2. Patient Information:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Name First Name    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street Address  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City, State Zip  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient ID: Specimen ID Phone #: |
| 1. **Ordering Clinician/ Phone# *(required)*:**   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  First Name Last Name Phone # | **4. Gender:**  **M**  **F**  **Other** **DOB: \_\_\_\_\_\_\_\_\_** |
| **5. Race:** (Check One)  American Indian or Alaska Native  Asian  Black or African American  ☐ Native Hawaiian or Pacific Islander ☐ White  Other | |
| **6. Ethnicity:** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino | |

**7. Test Requested:**  Mycobacteria testing panel (includes AFB smear, culture, and susceptibility testing, if indicated)

Nucleic Acid Amplification Test (NAAT) [Sputum, Tracheal Aspirate, BAL, or BW only]

Isolate identified by submitting site as Mycobacteria for confirmation. ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Culture, smear, Identification and Susceptibility will also be performed, if indicated.

**8. AFB Testing Completed by Submitting Facility on Specimen Prior to Submission?**

**N/A**  **AFB Smear** Result **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **MTB NAAT** Result **\_\_\_\_\_\_\_\_\_\_\_\_\_**  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Has this Specimen been Digested/Deconned Prior to Submission?**  **YES**  **NO**

**If YES- Chemical used:**  **NALC-NaOH**  Oxalic Acid  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. Collection Date:** *(required*) **\_\_\_\_\_\_\_\_\_\_\_ Collection Time:** *(required*) \_**\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **11. Specimen Source: (*required – one form per specimen)*** | | |
| **Primary Specimen Source (listed alphabetically)** | | |
| Abscess: Indicate Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Blood [whole blood] (no microscopy) \*  Bone Marrow  Body Fluid: Indicate Source\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Bronchoalveolar lavage (BAL) Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Bronchial Wash (BW)  CSF  Gastric Aspirate/Washing (neutralized prior to submission) \*  Laryngeal Swab (Throat Swab) | Lung Tissue: Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pleural Fluid  Sputum:  Expectorated  Induced  Stool  Tissue: Indicate Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Tracheal Aspirate  Urine  Wound: Indicate Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Culture Isolate or Positive MGIT/Versa Trek Broth:** Indicate type of media submitted | | |
| 7H11 Slant/Plate  7H10 Slant/Plate  LJ Slant  7H9 Broth  Chocolate Agar Slant/Plate  Blood Agar Slant/Plate  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_  Date Culture Isolate Inoculated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (when did the media being submitted get inoculated with the organism to ID?) | | Positive MGIT Broth  Versa Trek Positive Broth  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Broth detected as positive \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

\*Specimen collection instructions: <https://www.mass.gov/doc/specimen-collection-for-mycobacteriology-testing-instructions/download>