



Request for QuantiFERON-TB Gold Test In-Tube Method (QFT-IT)

MTS # 0001
CLIA #50D067204

LAB # (Lab use only)

Date received (Lab use only)

1. Patient Information – Required. Fill out form completely. Please print plainly.

Last name:	First name:	MI:
Chart number or other ID:	Male <input type="checkbox"/> Female <input type="checkbox"/>	DOB:
Age:		
Status of patient (circle): Positive PPD? Yes/No/Unk When: _____ mm _____ Exposed to MTB? Yes/No When: _____ Immunocompromised? Yes/No Describe: _____ Symptomatic for TB? Yes/No Other illnesses/conditions? Yes/No Describe: _____ _____ _____ _____	Race (circle): 1 Asian 2 Black/African American 3 White/Caucasian 4 Native Am/Alaska Nat. 5 Pac. Islander/Hawaiian 6 Other: Ethnicity: 1 Hispanic 2 Latino	Reason (circle): 1 Employment 2 Student 3 Foreign-born in U.S. <5 years 4 Contact investigation 5 High risk 6 Routine screening 7 Other:

2. Specimen Information – REQUIRED! (See specimen collection and handling instructions on the back)

Date collected:	<i>(Check one)</i> <input type="checkbox"/> Option 1: No incubation In-Tubes must arrive in Lab within 16 hours of collection (M-Th 8:00 – 3:30pm)
Time:	<input type="checkbox"/> Option 2: Incubate only In-Tubes must arrive in Lab within 3 days after incubation (M-Th 8:00 – 3:30pm) Date incubated: _____
	<input type="checkbox"/> Option 3: Incubate and centrifuge In-Tubes must arrive in Lab within 28 days (M-F 8:00 – 3:30pm) Date incubated: _____ Date centrifuged: _____

3. Mail Results To:

Provider:	Attention:		
Address:	City:	State:	Zip:
Phone:	Fax:		
<input type="checkbox"/> Fax requested. (Reports are mailed unless a FAX report is requested.)			

4. Bill To: Same as above

Provider:	Attention:		
Address:	City:	State:	Zip:

5. Comments: _____

