Advanced Diagnostic Laboratories National Jewish Health®

Client Services | 800.550.6227 | 303.270.2175 fax | njlabs.org

SHIP TO: National Jewish Health
Mycobacteriology Laboratory
1400 Jackson Street
Denver, CO 80206

Mycobacteriology Requisition

1. PATIENT INFORMATION

Patient Name (Last, First)

DOB __ __ / __ __ / __ __ __ __

☐ Male ☐ Female ☐ Neutral/Other ☐ Unknown

2. BILLING INFORMATION – INSTITUTIONAL BILLINGS ONLY		3. REPORT DELIVERY INFORMATION	
National Jewish Health Advanced Diagnostic Laboratories does not bill patients directly or third-party health insurance. Visit njlabs.org or call for details.		☐ Same as Billing Address	
		Client ID	
Client ID		Client Name	
Client Name		Address	
Address		City	State Zip
City State Zip		Phone	Secure Fax
Phone		☐ Duplicate Report Requested	Attn:
Secure Fax		Phone	Secure Fax

4. SUBMISSION INFORMATION

Actual specimen collection date ____________________ ☐ Cystic fibrosis patient ☐ History of *Pseudomonas* sp.

☐ Environmental (contact lab prior to collection). Specify source ____________________ ☐ Veterinary Specify animal ____________________

Submitter's Name ____________________ Phone ____________________

5. CULTURE & IDENTIFICATION

Isolate

Submitter ID of AFB: ____________________

Medium sent: ☐ Liquid ☐ Solid
Specify media ____________________

☐ MTB complex has already been ruled out.

☐ **Full identification needed**	AFB4
☐ Full identification from partial identification (includes *M. abscessus* subspeciation; MAC, MTBC speciation)	AFB4
☐ None requested (Not recommended for *M. abscessus* & *M. avium* complexes)	

Specimen (Swabs NOT recommended)

☐ **Smear, NAAT, culture, identification**	AFB1
☐ **Smear, culture, identification** (if low suspicion for TB)	AFB3
☐ Smear, culture & identification for TB only	VETCX
☐ Smear and culture only (uncommon request)	AFB7
☐ Culture and identification (environmental only)	ENVCX
Add on options:	
☐ **TB screen (NAAT) is needed**	AFB2
☐ Quantitative Culture (by serial dilution)	AFCFU

Source: ☐ BAL ☐ Sputum ☐ Induced sputum ☐ Blood
☐ Urine ☐ CSF ☐ Fresh tissue ☐ Fixed (FFPE) tissue (MTB NAAT only)

Tissue source ____________________

Suspected Organism ____________________

Other ____________________

6. ANTIMICROBIAL SUSCEPTIBILITY TESTING

☐ **Appropriate phenotypic susceptibilities and resistance gene testing (*recommended*).** Charges only applied to relevant testing.	APPRO
☐ Appropriate resistance gene testing. Charges only applied to relevant testing.	AFB6
☐ Customized phenotypic susceptibilities (please circle from the following):	
Performed on any mycobacteria: AMK, AZM, CIP, CLF, CLR, KAN, LZD, MXF	
Slow Growers only: CAP (Varies by organism), CS, DOX, EMB, ETH, LVX, MIN, OFX, RFB, RIF, STR, TMP/SXT, RIF/EMB synergy	NTM3
Rapid Growers only: AUG, FEP, FOT, FOX, AXO, DOX, GEN, IPM, MIN, TGC, TOB, TMP/SXT, CLF/AMK synergy	NTM5
MTB complex only: CAP, CS, EMB, ETH, INH, LVX, OFX, PAS, PZA, RFB, RIF, STR, PZA w/ MIC	MTB6
☐ Partial acid fast (e.g., *Gordonia* sp.): AMK, AUG, AZM, FEP, FOT, FOX, AXO, CIP, CLR, CLO, DOX, GEN, IPM, KAN, LZD, MIN, MXF, TGC, TOB, TMP/SXT, CLF/AMK synergy	NTM4
☐ None requested	

7. ADDITIONAL RESEARCH TESTING NEEDED

☐ NTM whole genome sequencing/Biorepository
CF Registry number ____________________

☐ NTM whole genome sequencing (prior consultation required)
Project number ____________________

☐ TB expression panel (prior consultation required)
Project number ____________________

☐ Custom genomic assay (prior consultation required)
Project number ____________________

INTERNAL USE ONLY