Molecular Detection of Drug Resistance Request Form

Laboratory Branch / Division of TB Elimination / CDC1600 Clifton Road, Atlanta, GA 30329
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Instructions: Please provide the following information and submit the completed form via email to <u>TBLab@cdc.gov</u> or fax at 404-639-5491. An email notification will be provided upon approval with further instructions.

Section 1. Laboratory Contact Information	
Date of Request:	Submitting Laboratory:
Contact Name:	Phone Number:
Fax Number:	E-mail Address:
Section 2. Sample Type / Specimen Identifier	
Patient or Sample ID:	Specimen Collection Date (Required):
Sample Type: (Select One)	
□ NAAT+ sediment; Specify specimen source:	
and AFB smear result:	
Section 3. Submission Criteria (check all that apply)	
☐ Known MDR; Test method:	
☐ Known RIF resistant; Test method:	
☐ Contact to known MDR ☐ Previously	Treated for TB
☐ From a country with a high rate of drug resistant TB; Specify:	
☐ Travel to / lived in a country with a high rate of drug resistant TB; Specify:	
☐ Mixed culture ☐ Non-viable in culture	☐ No / poor growth in DST media
☐ Clinical reason(s); Explain	
☐ Other (e.g., results needed for optional treatment regimen); Explain	
Has a sample from this patient been previously submitted to CDC? ☐ Yes ☐ No If yes, please provide reason for resubmission and the previous CDC Specimen ID(s):	