TEXAS Department of State Health Services

INFECTIOUS DISEASE INTERVENTION AND CONTROL BRANCH

Mycobacterium tuberculosis Genotyping Request

For special requests, call: 512- 458-7111, ext 6353 OR
Fax this form: 512- 458- 7787

Reason for Requesting Genotyping: *(This portion MUST be completed.)*
Check all that apply:

_____ Transmission during outbreak investigation
_____ Expand contact investigation
_____ Reactivation/relapse or reinfection*
_____ Suspected collection cross-contamination*
_____ Suspected laboratory cross-contamination*
_____ Other _____ *(Please specify)*

***Please submit a separate form for each additional culture submitted.**

DSHS Contact: _____ **Ext:** _____

Requestor:

Name of contact person: _____

Name of agency: _____

Address: _____

_____

Telephone #: (____)_____ Fax #: (____)_____

Contact email address (*required*): _____

Patient Data Information: *(Please print)*

Name (Lname, Fname): _____Date of birth: _____

Home address (city/state/zip): _____

_____ County: _____

Type of culture (sputum or tissue, if tissue, specify site): _____

Date of collection: _____

---------- *For DSHS use only*----------

Date request was received by genotyping coordinator: _____

Date DSHS received results: _____

Date result was reported to requestor: _____