N4

PHE Microbiology request form

Public Health England

QuantiFERON®-TB Gold Plus test

National Mycobacterium Reference Service-South (NMRS-South)
61 Colindale Ave,
London NW9 5HT

Phone +44 (0)20 832 76957
Email NMRS.South@phe.gov.uk
phe.nmrs-south@nhs.net
www.gov.uk/phe

PHE Colindale DX
6530016
COLINDALE NW

Please write clearly in dark ink

Withdrawn August 2023

SENDER'S INFORMATION

Sender's name and address

Postcode

Report to be sent FAO

Contact Phone Ext

Purchase order number

PATIENT / SOURCE INFORMATION

NHS number

Surname

Forename

Hospital number

Sex ☐ male ☐ female

Date of birth Age

Patient's postcode

Patient's HPT

Clinical / Patient's consultant

Patient's Occupation

SAMPLE INFORMATION

Your reference#

SAMPLE TYPE Date of collection D D M M Y Y Time

Date sent to PHE D D M M Y Y

Incubated 16 - 24 hours? ☐ Yes ☐ No

Do you suspect from clinical or lab information that patient is infected with Hazard Group 3 or 4 pathogen (in addition to the requested investigation)? If yes, give all relevant details

Note: If infection with a Hazard Group 4 pathogen is suspected, from clinical information or travel history, you must contact Reference Lab before sending

CLINICAL / EPIDEMIOLOGICAL INFORMATION

Was patient born in the UK? ☐ Yes ☐ No ☐ Don't know

If no, where?

When did patient come to UK (year)?

Has patient lived in, or spent more than 2 months travelling in another country? ☐ Yes ☐ No ☐ Don't know

If yes, where?

Patients clinical details

Is the patient taking any of the following medications

☐ None ☐ Steriods ☐ Cytotoxic drugs

☐ Other immunosuppressive drugs *(please specify)*

Is the patient

Immunocompromised? ☐ Yes ☐ No ☐ Don't know

HIV Positive? ☐ Yes ☐ No ☐ Don't know

Does patient have Diabetes? ☐ Yes ☐ No ☐ Don't know

Does the patient have any of the following?

☐ Fever ☐ Night sweats ☐ Loss of weight ☐ Cough

History of BCG vaccination and TB skin tests

BCG vaccination? ☐ Yes ☐ No ☐ Don't know

If yes, what age? ☐ Neonatal ☐ School *(13-14 yrs)* ☐ Other

BCG scar? ☐ Yes ☐ No

Mantoux test done? ☐ Yes ☐ No ☐ Don't know

Reading mm

Abnormal CXR? ☐ Yes ☐ No ☐ Don't know

If yes, specify the location:

	R	L
Upper		
Middle		
Lower		

Cavities? ☐ Yes ☐ No ☐ Don't know

☐ Unilateral ☐ Bilateral

Other relevant clinical data

History of TB disease, anti-TB treatment and contacts

Previous TB diagnosis? ☐ Yes ☐ No ☐ Don't know

If yes, when D D M M Y Y

Previous TB treatment? ☐ Yes ☐ No ☐ Don't know

Previous TB chemoprophylaxis? ☐ Yes ☐ No ☐ Don't know

Previous contact with TB? ☐ Yes ☐ No ☐ Don't know

If yes, when D D M M Y Y

Nature of contact?

☐ Household ☐ Work ☐ Study / School ☐ Prison

☐ Other *(please specify)*

REFERRED BY

Name Signature Date D D M M Y Y