CONFIDENTIAL LABORATORY REPORT

TO: L.A. County TB Control Program
2615 S. Grand Avenue, Room 507
Los Angeles, CA 90007
Telephone No.: (213) 744-6160
FAX No.: (213) 749-0926

FROM: Reporting Lab ______________________________
Referring Lab (if any) ________________________
Address ___________________________________
City, State, Zip _____________________________
Telephone No. _____________________________

Patient Name:	Physician Name:
Age/Birth Date:	Facility:
Gender:	
Identification No.:	
Address:	Address:
City, State, Zip:	City, State, Zip:
Telephone No.*:	Telephone No.:

*If known

Date of Collection: ________________ **Source:** _____________________ **Specimen #:** ________________

AFB Smear Results*

	Date Reported:
☐ Positive (Quantity ________) ☐ Negative ☐ Not Done	

Culture Results*

	Date Reported:
☐ Positive for AFB, identification to follow ☐ Positive for AFB, sent for identification to: ____________________________ (reference lab) ☐ Negative ☐ Not Done ☐ Overgrown	

Identification*

	Date Reported:
☐ *Mycobacterium tuberculosis* complex (________ colonies) Species, if known ____ ☐ *Mycobacterium* other than Tuberculosis complex: ________________________ ☐ Other ____	

Susceptibility Testing*

☐ To follow on separate sheet ☐ Sent to reference lab: ___________________________

Comments: ____

*** Each result must be reported within one working day of notifying the health care provider**