New Jersey Department of Health
Public Health and Environmental Laboratories
PO Box 361
Trenton, NJ 08625-0361

FOR LAB USE ONLY
Lab #
Date Received

REQUEST FOR QUANTIFERON-TB GOLD TEST IN-TUBE METHOD (QFT-IT)

CLIA #31D0881184

Fill out form completely. Please print clearly. Send with each set of samples.

PATIENT INFORMATION *(REQUIRED)*

Last Name | First Name

Address

City | State | Zip Code

Chart Number or Other ID ***(Required)***

Gender ☐ Male ☐ Female

Date of Birth _____ /_____ /_____

STATUS OF PATIENT

Initial Test?	☐ Yes	☐ No	
Repeated Test?	☐ Yes	☐ No	
Previous positive PPD? When?	☐ Yes	☐ No	☐ Unk
Had a live vaccine during the last 30 days?	☐ Yes	☐ No	
Exposed to MTB? When?	☐ Yes	☐ No	☐ Unk
Immunocompromised? Describe:	☐ Yes	☐ No	
Symptomatic for TB?	☐ Yes	☐ No	
Other Illnesses/Conditions? Describe:	☐ Yes	☐ No	
Previous BCG Vaccination? Date:	☐ Yes	☐ No	

Race
1 ☐ Asian
2 ☐ Black/African American
3 ☐ White/Caucasian
4 ☐ Native American/ Alaskan Native
5 ☐ Pacific Islander
6 ☐ Other

Ethnicity
1 ☐ Hispanic
2 ☐ Non-Hispanic

Reason for QFT-IT
1 ☐ Case/Suspect
2 ☐ Foreign-born, Less than 5 years in USA
3 ☐ Contact Investigation Index Case #: _____
4 ☐ Class: ☐B1 ☐B2
5 ☐ Student (K-12th Grade)
6 ☐ Other: _____

Country of Birth

SPECIMEN INFORMATION *(See specimen collection and handling instructions on back)*

Date/Time Collected: ☐ AM ☐ PM

Collector's Initials

Date/Time Placed in Incubator *(within 16 hours of collection)*: ☐ AM ☐ PM

Date/Time Removed from Incubator *(After 16-24 hours of incubation)*: ☐ AM ☐ PM

SUBMITTER/REQUESTER INFORMATION

Provider | Site # | Attention:

Address

City | State | Zip Code

Telephone | Fax | Fax Report Requested? ☐ Yes ☐ No *(Reports are mailed unless a FAX report is requested)*

Ordering Physician *(Print)* | Signature | Date

LAB-10
MAY 14

☐ Fax Copy of Request to TB (609) 826-4879