Form 207
Revised 09/2018

"This form, when filled in, contains patient information that must be protected in accordance with the Health Insurance Portability & Accountability Act."

KY Division of Laboratory Services
100 Sower Blvd., North Loading Dock, P.O. Box 2020
Frankfort, Kentucky 40602-2020
Phone: 502/564-4446 Fax: 502/564-7019

Kentucky Public Health
Prevent. Promote. Protect.

Mycobacteriology

Please complete a separate form for each specimen.

PATIENT INFORMATION:

Name (Last, First, MI)

Social Security # Sex Race Age DOB

Home Address

City State Zip Code County

Send Report To:

Submitter

Street Address (PO BOX)

City State Zip Code

Requesting Physician (if other than submitter)

Please Use "L" Label or Fill in Completely

Specimen Information:

Date of Collection_____

☐ **Clinical Specimen**
- ☐ Sputum
- ☐ Bronchial Washing
- ☐ Gastric fluid
- ☐ Urine
- ☐ CSF
- ☐ Other, please specify_____

☐ **Referred Specimen (Culture)**
Source:_____

Hospital or Laboratory reference number (if applicable_____)

Is the patient on anti-tuberculosis drugs? ☐ Yes ☐ No

Laboratory Findings:

Laboratory Number: