

## TB Genotyping Request Form

Submitter Information			
Health Unit/Institution			
Address		City	Postal Code
Contact Person (Name, Title)		Phone	Fax
Email			

Suspect Cluster: Patient Information					
1.	Last Name	First Name	DOB (yyyy-mm-dd)	HIN#	Diagnosis Date (yyyy-mm-dd)
PHL Lab #	iPHIS Client #	Reason for suspected match: <input type="checkbox"/> Family <input type="checkbox"/> Workplace <input type="checkbox"/> Known Contact <input type="checkbox"/> Other			Specify:
Match against:					Specify:
<input type="checkbox"/> Entire database <input type="checkbox"/> Homeless cluster <input type="checkbox"/> Patient 2 <input type="checkbox"/> Patient 3 <input type="checkbox"/> Other					
2.	Last Name	First Name	DOB (yyyy-mm-dd)	HIN#	Diagnosis Date (yyyy-mm-dd)
PHL Lab #	iPHIS Client #	Reason for suspected match: <input type="checkbox"/> Family <input type="checkbox"/> Workplace <input type="checkbox"/> Known Contact <input type="checkbox"/> Other			Specify:
Match against:					Specify:
<input type="checkbox"/> Entire database <input type="checkbox"/> Homeless cluster <input type="checkbox"/> Patient 1 <input type="checkbox"/> Patient 3 <input type="checkbox"/> Other					
3.	Last Name	First Name	DOB (yyyy-mm-dd)	HIN#	Diagnosis Date (yyyy-mm-dd)
PHL Lab #	iPHIS Client #	Reason for suspected match: <input type="checkbox"/> Family <input type="checkbox"/> Workplace <input type="checkbox"/> Known Contact <input type="checkbox"/> Other			Specify:
Match against:					Specify:
<input type="checkbox"/> Entire database <input type="checkbox"/> Homeless cluster <input type="checkbox"/> Patient 1 <input type="checkbox"/> Patient 2 <input type="checkbox"/> Other					

Additional Information
Additional Comments:

**Please fill in this form electronically, print, and then fax to the PHL  
Toronto TB and Mycobacteriology Laboratory at  
416-235-6013**

For any questions please contact Dr. Frances Jamieson at 416-235-5841