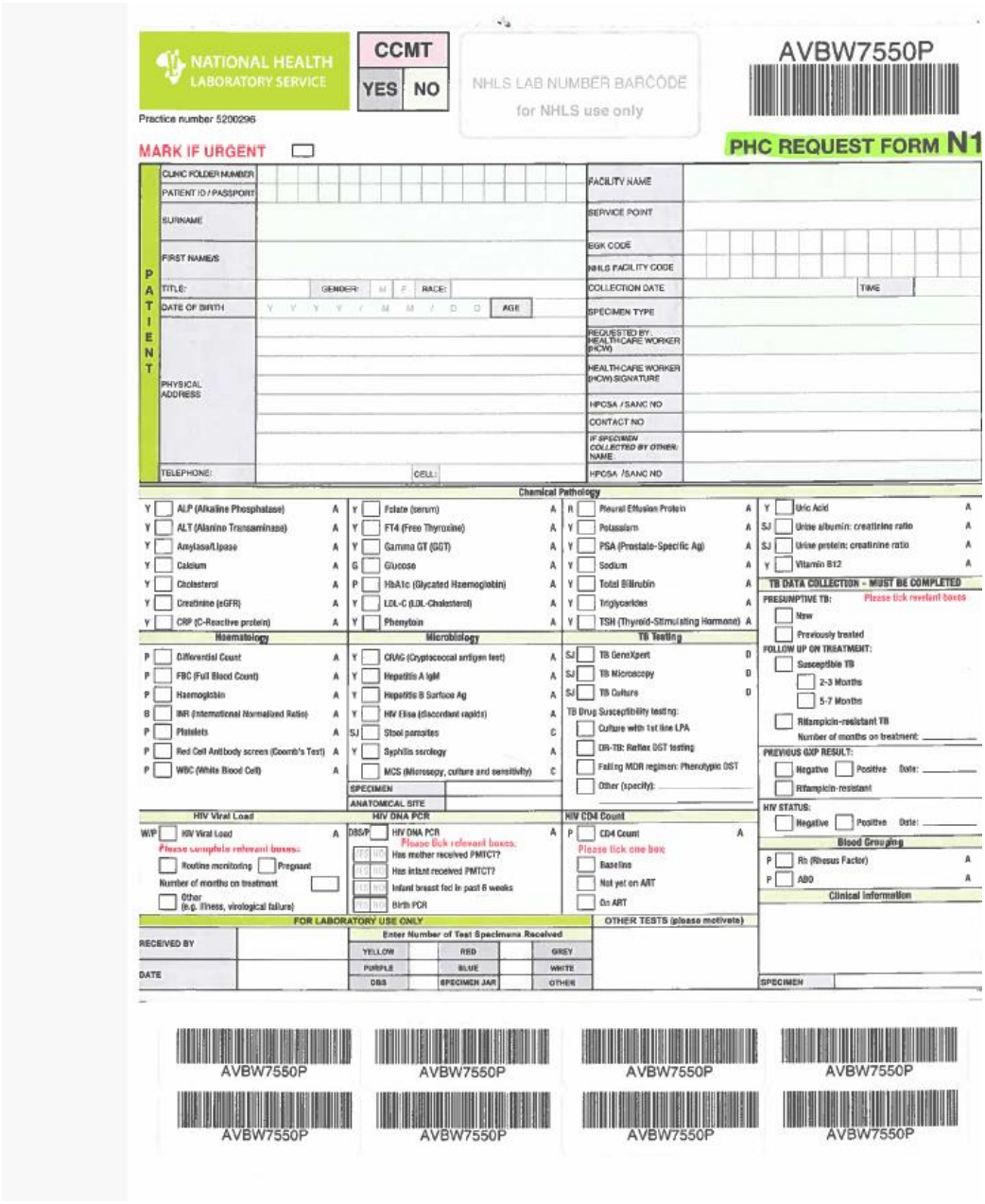
. **Terms of Reference / Scope of Works / Specifications**



NATIONAL HEALTH LABORATORY SERVICE

CCMT YES NO

NHLS LAB NUMBER BARCODE for NHLS use only

AVBW7550P

Practice number 5200296

MARK IF URGENT

PHC REQUEST FORM N1

PATIENT

CLINIC FOLDER NUMBER
PATIENT ID / PASSPORT
SURNAME
FIRST NAME/S
TITLE: GENDER: M F RACE:
DATE OF BIRTH Y Y Y Y / M M / D D AGE
PHYSICAL ADDRESS
TELEPHONE: CELL:

FACILITY NAME
SERVICE POINT
EGK CODE
NHLS FACILITY CODE
COLLECTION DATE TIME
SPECIMEN TYPE
REQUESTED BY: HEALTHCARE WORKER (HCW)
HEALTHCARE WORKER (HCW) SIGNATURE
HPCSA / SANC NO
CONTACT NO
IF SPECIMEN COLLECTED BY OTHER: NAME
HPCSA /SANC NO

Chemical Pathology

Y ALP (Alkaline Phosphatase) A
Y ALT (Alanine Transaminase) A
Y Amylase/Lipase A
Y Calcium A
Y Cholesterol A
Y Creatinine (eGFR) A
Y CRP (C-Reactive protein) A
Y Folate (serum) A
Y FT4 (Free Thyroxine) A
Y Gamma GT (GGT) A
G Glucose A
P HbA1c (Glycated Haemoglobin) A
Y LDL-C (LDL-Cholesterol) A
Y Phenytoin A
R Pleural Effusion Protein A
Y Potassium A
Y PSA (Prostate-Specific Ag) A
Y Sodium A
Y Total Bilirubin A
Y Triglycerides A
Y TSH (Thyroid-Stimulating Hormone) A
Y Uric Acid A
SJ Urine albumin: creatinine ratio A
SJ Urine protein: creatinine ratio A
Y Vitamin B12 A

Haematology

P Differential Count A
P FBC (Full Blood Count) A
P Haemoglobin A
B INR (International Normalized Ratio) A
P Platelets A
P Red Cell Antibody screen (Coomb's Test) A
P WBC (White Blood Cell) A

Microbiology

Y CRAG (Cryptococcal antigen test) A
Y Hepatitis A IgM A
Y Hepatitis B Surface Ag A
Y HIV Elisa (Discordant rapids) A
SJ Stool parasites C
Y Syphilis serology A
MCS (Microscopy, culture and sensitivity) C
SPECIMEN
ANATOMICAL SITE

TB Testing

SJ TB GeneXpert D
SJ TB Microscopy D
SJ TB Culture D
TB Drug Susceptibility testing:
Culture with 1st line LPA
DR-TB: Reflex DST testing
Failing MDR regimen: Phenotypic DST
Other (specify):

TB DATA COLLECTION - MUST BE COMPLETED

PRESUMPTIVE TB: Please tick relevant boxes
New
Previously treated
FOLLOW UP ON TREATMENT:
Susceptible TB
2-3 Months
5-7 Months
Rifampicin-resistant TB
Number of months on treatment:
PREVIOUS GXP RESULT:
Negative Positive Date:
Rifampicin-resistant
HIV STATUS:
Negative Positive Date:

HIV Viral Load

W/P HIV Viral Load A
Please complete relevant boxes:
Routine monitoring Pregnant
Number of months on treatment
Other (e.g. Illness, virological failure)

HIV DNA PCR

DBS/P HIV DNA PCR A
Please tick relevant boxes.
Has mother received PMTCT?
Has infant received PMTCT?
Infant breast fed in past 6 weeks
Birth PCR

HIV CD4 Count

P CD4 Count A
Please tick one box
Baseline
Not yet on ART
On ART

Blood Grouping

P Rh (Rhesus Factor) A
P ABO A

Clinical Information

FOR LABORATORY USE ONLY

RECEIVED BY
DATE

Enter Number of Test Specimens Received

YELLOW RED GREY
PURPLE BLUE WHITE
DBS SPECIMEN JAR OTHER

OTHER TESTS (please motivate)

SPECIMEN

AVBW7550P AVBW7550P AVBW7550P AVBW7550P
AVBW7550P AVBW7550P AVBW7550P AVBW7550P

NATIONAL HEALTH LABORATORY SERVICE

PHC Facility Specimen Register N4

No: 15506550

umber	Date of Sample Collection	Place Request form Barcode here	Patient Folder Number	Tests Requested	Date of receipt of results
1		PLACE BARCODE HERE		Chemical Pathology ☐ Cytopathology ☐ Haematology ☐ HIV ☐ Microbiology ☐ TB ☐	Chemical Pathology DD / MM / YYYY Cytopathology DD / MM / YYYY Haematology DD / MM / YYYY HIV DD / MM / YYYY Microbiology DD / MM / YYYY TB DD / MM / YYYY
2		PLACE BARCODE HERE		Chemical Pathology ☐ Cytopathology ☐ Haematology ☐ HIV ☐ Microbiology ☐ TB ☐	Chemical Pathology DD / MM / YYYY Cytopathology DD / MM / YYYY Haematology DD / MM / YYYY HIV DD / MM / YYYY Microbiology DD / MM / YYYY TB DD / MM / YYYY
3		PLACE BARCODE HERE		Chemical Pathology ☐ Cytopathology ☐ Haematology ☐ HIV ☐ Microbiology ☐ TB ☐	Chemical Pathology DD / MM / YYYY Cytopathology DD / MM / YYYY Haematology DD / MM / YYYY HIV DD / MM / YYYY Microbiology DD / MM / YYYY TB DD / MM / YYYY
4		PLACE BARCODE HERE		Chemical Pathology ☐ Cytopathology ☐ Haematology ☐ HIV ☐ Microbiology ☐ TB ☐	Chemical Pathology DD / MM / YYYY Cytopathology DD / MM / YYYY Haematology DD / MM / YYYY HIV DD / MM / YYYY Microbiology DD / MM / YYYY TB DD / MM / YYYY
5		PLACE BARCODE HERE		Chemical Pathology ☐ Cytopathology ☐ Haematology ☐ HIV ☐ Microbiology ☐ TB ☐	Chemical Pathology DD / MM / YYYY Cytopathology DD / MM / YYYY Haematology DD / MM / YYYY HIV DD / MM / YYYY Microbiology DD / MM / YYYY TB DD / MM / YYYY
6		PLACE BARCODE HERE		Chemical Pathology ☐ Cytopathology ☐ Haematology ☐ HIV ☐ Microbiology ☐ TB ☐	Chemical Pathology DD / MM / YYYY Cytopathology DD / MM / YYYY Haematology DD / MM / YYYY HIV DD / MM / YYYY Microbiology DD / MM / YYYY TB DD / MM / YYYY
7		PLACE BARCODE HERE		Chemical Pathology ☐ Cytopathology ☐ Haematology ☐ HIV ☐ Microbiology ☐ TB ☐	Chemical Pathology DD / MM / YYYY Cytopathology DD / MM / YYYY Haematology DD / MM / YYYY HIV DD / MM / YYYY Microbiology DD / MM / YYYY TB DD / MM / YYYY
8		PLACE BARCODE HERE		Chemical Pathology ☐ Cytopathology ☐ Haematology ☐ HIV ☐ Microbiology ☐ TB ☐	Chemical Pathology DD / MM / YYYY Cytopathology DD / MM / YYYY Haematology DD / MM / YYYY HIV DD / MM / YYYY Microbiology DD / MM / YYYY TB DD / MM / YYYY

Local Laboratory Name	PHC ORDER Book
Health Facility Name	
Health Facility Address	
Health Facility Contact Number	
Name of Requestor	
Date requested:	

NATIONAL HEALTH LABORATORY SERVICE

No: 3026550

REQUEST FORM N3

Facility Manager Name	
Facility Manager Signature	

PHC Specimen Collection Material Order Form

Category	Description		Unit of Measure	Stock on Hand	Quantity Requested	Laboratory to complete: Quantity Approved in Laboratory	Laboratory to complete: Quantity Supplied	Acknowledgement of Receipt
Request Forms	PHC Request Form	N1	50 Forms per book					
	Cytology Request Form	N2	50 Forms per book					
	PHC Order Book Material for specimen collection	N3	25 Sets per book					
	PHC Facility Specimen Register	N4	50 Forms per book					
Specimen Collection Materials	Vacutainer tube: Red Top		Tube					
	Vacutainer tube: Blue Top (Sodium Citrate)		Tube					
	Vacutainer tube: Yellow Top (SST)		Tube					
	Vacutainer tube: Grey Top (Sodium Fluoride)		Tube					
	Vacutainer tube: White Top (PPT)		Tube					
	Vacutainer tube: Purple Top (EDTA)		Tube					
	Microtainer: Purple (EDTA Paeds)		Tube					
	Microtainer: Yellow (SST-Paeds)		Tube					
	Needles (Black)		Box (100)					
	Needles (Green)		Box (100)					
	Swabs with transport medium		Swab					
	Sterile Tubes (without additive) for MC&S		Tubes					
	Sterile specimen jars		Jars					
	Specimen plastic bags		Roll (50)					
Pap smear collection materials	Liquid-based Cytology (LBC) Vials		Pack (25)					
	Combi-brush		Pack (25)					
	Cervex-brush		Pack (25)					
	Fixative		Can					
	Wooden spatula		Pack (50)					
	Slide holder / Envelope		Each					
	Microscope slides		Pack (50)					
Early Infant Diagnosis (EID)	DBS PCR kit		100 Kits					
SMS Printer	Thermal paper roll		Rolls					

Motivation for additional specimen collection material, e.g. campaign

TO BE COMPLETED BY COURIER AND LABORATORY STAFF

Collection by Courier		Order Received by Laboratory		Despatch by Laboratory		Materials Received by Facility	
Name		Name		Name		Name	
Signature		Signature		Signature		Signature	
Date		Date		Date		Date	

NATIONAL HEALTH LABORATORY SERVICE

Practice number 5200296

CYTOLOGY N2

CCMT | YES | NO

Cytology Pg.1

NHLS LAB NUMBER BARCODE

FOR NHLS USE ONLY

ACSA8050CNF

SECTION A

LOC

CHC / CLINIC / HOSP	
WARD	
eGK APPROV. CODE	
COPY REPORT TO	

SPEC

SPECIMEN	
ANATOMICAL SITE	
COLLECTION DATE	TIME
COLLECTED BY	

PATIENT

PATIENT ID NO	ID / Passport
HOSPITAL NUMBER	
SURNAME	
FIRST NAME	SEX M F
DATE OF BIRTH D D / M M / Y Y Y Y	AGE
RACE	TITLE
PATIENT ADDRESS	
PATIENT TEL NO	H W C

CLIN

ICD10 DIAGNOSIS CODES

Warfarin | Heparin

HCW

HCW NAME	
HPCSA / SANC NO	
PRACTICE NO	
CONTACT NO	
EMAIL ADDRESS	
HCW SIGNATURE	

PRIVATE ACCOUNT

AUTHORISATION NO	FEE CLASS
MEDICAL AID	PLAN
MEDICAL AID NO	DEP CODE
MEMBER NAME	
MEMBER ID NO	
MEMBER ADDRESS	
MEMBER TEL NO	
EMPLOYER	
MEMBER'S SIGNATURE	

I consent to tests and take responsibility for payment of this account

SPECIMEN TYPE

- ☐ CONVENTIONAL SMEAR R146.02
- ☐ Liquid based specimen R186.99
- ☐ OTHER (please specify)

PREVIOUS CYTOLOGY

DATE ___ / ___ / ___ Y N

CYTOLOGY NO: ___

CYTOLOGY DIAGNOSIS: ___

LAST RELEVANT SURGERY / PATHOLOGY

DATE ___ / ___ / ___ Y N

SPECIMEN NO(S): ___

SPECIMEN TYPE: ___

DIAGNOSIS: ___

RADIATION

DATE ___ / ___ / ___ Y N

AREA: ___

CHEMOTHERAPY

DATE ___ / ___ / ___ Y N

TYPE: ___

SECTION B

✓ GYNAECOLOGICAL

LMP

DATE ___ / ___ / ___

CONTRACEPTION / HRT Y N

TYPE: ___

PREGNANT WEEKS

POST PARTUM WEEKS

Y N POSTMENOPAUSAL

Y N POST MENOP. BLEED

Period of bleeding: ___

RETRO VIRUS + - ? Rx

SYMPTOMATIC / DIAGNOSTIC ☐

OR

CERVICAL SCREENING PROGRAMME ☐

ORIGIN OF SMEAR / SPECIMEN

- ☐ Cervix
- ☐ Endocervix
- ☐ Vagina
- ☐ Vault
- ☐ Endometrium
- ☐ Other: Specify ___

CONDITION OF CERVIX

- ☐ HEALTHY
- ☐ INFLAMMATORY
- ☐ SUSPECTED CA

SMEAR / SPECIMEN TAKEN WITH

- ☐ Spatula
- ☐ Endocervical Brush / Broom
- ☐ Endometrial Endopap
- ☐ Other: Specify ___

SECTION C

GENERAL CYTOLOGY

✓ ORIGIN OF SPECIMEN / ORGAN

URINARY TRACT

- ☐ Bladder
- ☐ Kidney L / R
- ☐ Ureter L / R
- ☐ Other: Specify ___

RESPIRATORY

- ☐ Trachea
- ☐ Bronchus L / R
- ☐ Lung L / R

FLUID

- ☐ Pleural L / R
- ☐ Pericardial
- ☐ Peritoneal
- ☐ CSF
- ☐ Other: Specify ___

LYMPH NODES

- ☐ Supraclavicular L / R
- ☐ Cervical (Neck) L / R
- ☐ Axillary L / R
- ☐ Inguinal L / R
- ☐ Other: Specify ___

HEAD AND NECK

- ☐ Mouth (Spec) ___
- ☐ Salivary Gland (Spec) ___
- ☐ Larynx
- ☐ Thyroid ___

GASTROINTESTINAL

- ☐ Oesophagus
- ☐ Pancreas
- ☐ Liver
- ☐ Other: Specify ___

BREAST

- ☐ Breast L / R
- ☐ Nipple discharge L / R

OTHER (PLEASE SPECIFY)

- ☐ Other e.g. Eye, Skin, Prostate, Hydrocoele, Testis, Ovary, Synovial, Bone, Soft tissue

✓ TYPE OF SPECIMEN

- ☐ Sputum
- ☐ Urine (voided)
- ☐ Urine (catheter/scope)
- ☐ Smear
- ☐ Imprint
- ☐ Washing / lavage
- ☐ Brush
- ☐ Suction aspiration
- ☐ Fine needle aspiration (FNA)
- ☐ Other: ___

SECTION D

CLINICAL DETAILS

LOC - Location detail • HCW - Healthcare Worker • SPEC - Specimen • CLIN - Clinical detail • CCMT - Conditional Grant

RECEIVED DATE D D M M Y Y

LABORATORY STAFF CODE

PREPARED BY

TIME H

VOLUME M L

MACROSCOPIC APPEARANCE/QUALITY

FNA PERFORMED BY

SCORE

NUMBER OF SMEARS PAP MGG H+E

SPECIAL STAINS: DATE

URGENT RESULTS CONVEYED TELEPHONICALLY / FAXED

TO:

BY: DATE: / / TIME: H

GYNAE

SPECIMEN TYPE: CONVENTIONAL SMEAR LBC

SELF COLLECTED SAMPLE OTHER (please specify)

SATISFACTORY FOR EVALUATION: Y N

REASONS FOR UNSATISFACTORY/ LIMITING FACTORS

DIAGNOSIS:

MICRO-ORGANISMS:

ADDITIONAL FINDINGS:

ANCILLARY TESTING:

RECOMMENDATIONS:

NON-GYNAE

CLINICAL HISTORY:

FINAL DIAGNOSIS:

DIFFERENTIAL DIAGNOSIS:

MICRO-ORGANISMS:

ADDITIONAL FINDINGS:

OTHER / SPECIAL STAIN RESULT:

RECOMMENDATIONS:

SNOMED code: 1 2 3 4 5 6 1 2 3 4 5 6 1 2 3 4 5 6 1 2 3 4 5 6

COMMENTS:

Scr/Reg/MO/Path 1: 1 2 3 4 / /

Scr/Reg/MO/Path 2: 1 2 3 4 / /

IR/R: 1 2 3 4 / /

Chk/MO/Path 1: 1 2 3 4 / /

Chk/MO/Path 2: 1 2 3 4 / /

SIGNED OUT ON BEHALF OF: / /

ACSA8050CNF ACSA8050CNF ACSA8050CNF

ACSA8050CNF ACSA8050CNF ACSA8050CNF

NATIONAL HEALTH LABORATORY SERVICE

Practice number 5200296

NHLS LAB NUMBER BARCODE

AFCC8150R

HOSPITALS: REGIONAL AND ABOVE

MARK IF URGENT ☐

REGIONAL PAGE 1

LOC

HOSPITAL	
WARD	
eGK APPROV. CODE	
COPY REPORT TO	

SPEC

SPECIMEN	
ANATOMICAL SITE	
COLLECTION DATE	TIME
COLLECTED BY	

PATIENT

PATIENT ID NO	ID / Passport
HOSPITAL NUMBER	
SURNAME	
FIRST NAME	SEX M F
DATE OF BIRTH (D D / M M / Y Y Y Y)	AGE
RACE	TITLE
PATIENT ADDRESS	
PATIENT TEL NO	H: W: C:

CLIN

ICD10 DIAGNOSIS CODES

Warfarin | Heparin

HCW

CLINICIAN / HCW NAME	
HPCSA / SANC NO	
PRACTICE NO	
CONTACT NO	
EMAIL ADDRESS	
CLINICIAN'S SIGNATURE	

PRIVATE ACCOUNT

AUTHORISATION NO	FEE CLASS
MEDICAL A/D	PLAN
MEDICAL A/D NO	DEP CODE
MEMBER NAME	
MEMBER ID NO	
MEMBER ADDRESS	
MEMBER TEL NO	
EMPLOYER	
MEMBER'S SIGNATURE	I consent to tests and take responsibility for payment of this account

HAEMATOLOGY

P	☐ Full blood count	R52
P	☐ Differential count	R29
P	☐ Haemoglobin	R16
P	☐ White cell count	R16
P	☐ Platelet count	R19
P	☐ Reticulocyte count	R26
B	☐ INR	R43
B	☐ PTT	R47
B	☐ D-dimers	
BL	☐ ESR	R26
P	☐ Direct Coombs	R31
P	☐ Indirect Coombs	R31

CHEMICAL PATHOLOGY

Y	☐ Sodium	R27
Y	☐ Potassium	R27
Y	☐ Chloride	R20
Y	☐ Bicarbonate	R38
Y	☐ Urea	R27
Y	☐ Creatinine	R27
Y	☐ Calcium	R27
Y	☐ Corrected calcium	R53
Y	☐ Magnesium	R27
Y	☐ Inorganic phospate	R27
Y	☐ Uric acid	R29
Y	☐ Total protein	R23
Y	☐ Albumin	R36
Y	☐ Total bilirubin	R32
Y	☐ Conjugated bilirubin	R36
Y	☐ ALT	R41
Y	☐ AST	R41
Y	☐ ALP	R39
Y	☐ GGT	R41
Y	☐ Creatine kinase	R44
Y	☐ Troponin	R152
Y	☐ Total Cholesterol	R41
Y	☐ Triglyceride	R60
Y	☐ C-reactive protein	R66
Y	☐ Iron	R54
Y	☐ Transferrin	R89
Y	☐ PSA	R117
Y	☐ TSH	R158
Y	☐ Free T4	R133
Grey	☐ Glucose - random	R27
Grey	☐ Glucose - fasting	R27
P	☐ HbA1c	R77
Urine	☐ U albumin:creat ratio	R51
CSF	☐ CSF chloride	R20
CSF	☐ CSF protein	R23
Grey	☐ CSF glucose	R27

SEROLOGY

Y	☐ Syphilis serology	>R18
Y	Clinical hepatitis ☐ A ☐ B ☐ C	R113 ea
Y	Hepatitis immunity ☐ A ☐ B	R113 ea

MICROBIOLOGY

- ☐ MC & S
- ☐ Blood culture
- ☐ Fungal microscopy & culture
- ☐ Parasites
- ☐ Cryptococcal antigen
- ☐ CSF cell count, MC & S
- ☐ Malaria

OTHER TESTS

For all TB and HIV - specific tests: TURN OVER FORM

INIPRINT-F VERSION NRF0301

P02A1394

FOR LABORATORY USE ONLY				
Yellow / Red with gel		Purple		Received
Red without gel		Grey		
White (PPT)		Blue		
Blood culture		Black		
Sterile screwtop tube		Green		Labelled
Specimen container		DBS		
Other				

NHLS LAB NUMBER

NHLS LAB NUMBER

LOC - Location detail • HCW - Healthcare Worker • SPEC - Specimen • CLIN - Clinical detail

NATIONAL HEALTH LABORATORY SERVICE

Practice number 5200296

NATIONAL PRIORITY PROGRAMME

NHLS LAB NUMBER BARCODE

AFCC8150R

REGIONAL PAGE 2

TB TESTS

SUSPECTED TB (PRE-TREATMENT):

- ☐ TB GeneXpert R173
- ☐ TB Microscopy R24
- ☐ TB Culture >R96

ON TREATMENT (MONITORING)

- ☐ TB Microscopy R24
- ☐ TB Culture >R96

DRUG SUSCEPTIBILITY TESTING:

- ☐ 1st line / Line probe (rifampicin and isoniazid) R178
- ☐ 2nd line R71

FOLLOW UP (only if smear pos after 7 weeks or treatment interuptions)

- ☐ TB GeneXpert R173

TB DATA COLLECTION - MUST BE COMPLETED

SUSPECTED TB (PRE-TREATMENT): DS: drug sensitive DR: drug resistant

Tick all that apply ✓

- ☐ Suspected **DS-TB** (not on treatment)
- ☐ Suspected **DR-TB** (not on treatment)
- ☐ Previously treated for **DS-TB**
- ☐ Previously treated for **DR-TB**

ON TREATMENT (MONITORING): Number of months on treatment

- ☐ **DS-TB** (on treatment) ☐ 2-3 mnths ☐ 4-7 mnths
- ☐ **DR-TB** (on treatment) ☐ 1-3 mnths ☐ 4-7 mnths ☐ > 7 mnths
- ☐ **DS-TB** failing treatment or persistently smear-positive ☐ 2-3 mnths ☐ 4-7 mnths ☐ > 7 mnths

COMMENTS / OTHER TESTS:

PATIENT'S HIV STATUS:

Pos ☐ Neg ☐ Unknown ☐

HIV - SPECIFIC TESTS

HIV DATA COLLECTION - MUST BE COMPLETED

Y ☐ HIV serology R50

If ordering HIV serology, please supply:

Clinic's HIV rapid result (if available): _____

P ☐ CD4 count (PLG) R60

If ordering CD4 count, please tick one category:

- A1 ☐ First ever CD4 count
- A2 ☐ CD4 count taken previously, not yet in ART care
- A3 ☐ In ART care (please mark current drugs)

W P ☐ HIV Viral Load R306

If ordering HIV viral load, please tick one category:

- B1 ☐ First ever viral load (paediatric)
- B2 ☐ Routine monitoring
- B3 ☐ Other (e.g. illness, virological failure)

DBS ☐ HIV PCR R342

If ordering HIV PCR, please answer:

- Has mother received PMTCT? Yes ☐ No ☐
- Has infant received PMTCT? Yes ☐ No ☐
- Infant breastfed in past 6 weeks? Yes ☐ No ☐

P ☐ HIV Drug Resistance R1872

HIV drug resistance genotype testing **will not be done** if the HIV status, results and treatment questions are not completed.

The DOH has approved HIV drug resistance genotype testing only for certain categories.

If ordering HIVDR, please tick one category and supply results:

- ☐ Baseline testing
- ☐ 1st line failure
- ☐ 2nd line failure
- ☐ 3rd line failure

HIV viral load previous: _____ Date _____

HIV viral load latest: _____ Date _____

Latest CD4 count: _____ Date: _____

Please tick current and previous ARV drugs

According to national ARV guidelines virological failure is defined as 2 consecutive viral loads > 1000 cp/ml at least 2 months apart.

Months on ARV treatment:

- C1 ☐ Baseline / work-up
- C2 ☐ 6 months
- C3 ☐ 12 months
- C4 ☐ 24 months
- C5 ☐ 36 months
- C6 ☐ Other

Currently off ART due to:

- D1 ☐ Adverse event
- D2 ☐ Non-adherence
- D3 ☐ Toxicity
- D4 ☐ Other

Current ARV drugs:

- ☐ FDC (Fixed dose combination)
- ☐ AZT ☐ 3TC ☐ EFV
- ☐ ABC ☐ ddI ☐ NVP
- ☐ TDF ☐ d4T ☐ LPV/r
- ☐ Other ARVs: _____

Previous ARV drugs:

- ☐ FDC (Fixed dose combination)
- ☐ AZT ☐ 3TC ☐ EFV
- ☐ ABC ☐ ddI ☐ NVP
- ☐ TDF ☐ d4T ☐ LPV/r
- ☐ Other ARVs: _____

AFCC8150R AFCC8150R AFCC8150R

AFCC8150R AFCC8150R AFCC8150R

NATIONAL HEALTH LABORATORY SERVICE

Practice number 5200296

DISTRICT HOSPITALS

MARK IF URGENT ☐

NHLS LAB NUMBER BARCODE

AFCS0750D

District Page 1

LOC	
	HOSPITAL
	WARD
	eDK APPROV. CODE
	COPY REPORT TO

SPEC	
	SPECIMEN
	ANATOMICAL SITE
	COLLECTION DATE / TIME
	COLLECTED BY

PATIENT	
	PATIENT ID NO / ID / Passport
	HOSPITAL NUMBER
	SURNAME
	FIRST NAME / SEX M F
	DATE OF BIRTH D D / M M / Y Y Y Y / AGE
	RACE / TITLE
	PATIENT ADDRESS
	PATIENT TEL NO H: W: C:

CLIN	
	ICD10 DIAGNOSIS CODES
	Warfarin / Heparin

HCW	
	CLINICIAN / HCW NAME
	HPCSA / SANC NO
	PRACTICE NO
	CONTACT NO
	EMAIL ADDRESS
	CLINICIAN'S SIGNATURE

PRIVATE ACCOUNT			
	AUTHORISATION NO	FEE CLASS	
	MEDICAL AID	PLAN	
	MEDICAL AID NO	DEP CODE	
	MEMBER NAME		
	MEMBER ID NO		
	MEMBER ADDRESS		
	MEMBER TEL NO		
	EMPLOYER		
	MEMBER'S SIGNATURE	I consent to tests and take responsibility for payment of this account	

HAEMATOLOGY

P	☐	Full blood count	R52
P	☐	Differential count	R29
P	☐	Haemoglobin	R16
P	☐	White cell count	R16
P	☐	Platelet count	R19
P	☐	Reticulocyte count	R26
B	☐	INR	R43
B	☐	PTT	R47
B	☐	D-dimers	
P	☐	Rhesus factor	R31
P	☐	Direct Coombs	R31
P	☐	Indirect Coombs	R31
BL	☐	ESR	R26

CHEMICAL PATHOLOGY

Y	☐	Sodium	R27
Y	☐	Potassium	R27
Y	☐	Creatinine	R27
Y	☐	ALT	R41
Y	☐	ALP	R39
Y	☐	Total Cholesterol	R41
Y	☐	Triglyceride	R60
Y	☐	HDL cholesterol	R52
Y	☐	C-reactive protein	R56
Grey	☐	Glucose - fasting	R27
P	☐	HbA1c	R77
Y	☐	TSH	R158
Y	☐	Free T4	R113
Y	☐	PSA	R117
Urine	☐	U protein:creat ratio	R51
Urine	☐	U albumin:creat ratio	R93
Fluid	☐	Fluid ADA	R41
Fluid	☐	Fluid protein	R23

SEROLOGY

Y	☐	Syphilis serology	>R18
Y		Clinical hepatitis	
	☐ A ☐ B ☐ C		R113 ea
Y		Hepatitis immunity	
	☐ A ☐ B		R113 ea

MICROBIOLOGY

- ☐ MC & S
- ☐ Blood culture
- ☐ Fungal microscopy & culture
- ☐ Parasites
- ☐ Cryptococcal antigen
- ☐ CSF cell count, MC & S
- ☐ Malaria

OTHER TESTS

For all TB and HIV - specific tests: TURN OVER FORM

UNIPRINT-F VERSION NRF0201

P02A1383

FOR LABORATORY USE ONLY				
Yellow / Red with gel		Purple		Received
Red without gel		Grey		
White (PPT)		Blue		
Blood culture		Black		
Sterile screwtop tube		Green		Labelled
Specimen container		DBS		
Other				

NHLS LAB NUMBER

NHLS LAB NUMBER

LOC - Location detail • HCW - Healthcare Worker • SPEC - Specimen • CLIN - Clinical detail

NATIONAL HEALTH LABORATORY SERVICE

Practice number 5200296

NATIONAL PRIORITY PROGRAMME

NHLS LAB NUMBER BARCODE

DISTRICT PAGE 2

AFCS0750D

TB TESTS

SUSPECTED TB (PRE-TREATMENT):

- ☐ TB GeneXpert R173
- ☐ TB Microscopy R24
- ☐ TB Culture >R98

ON TREATMENT (MONITORING)

- ☐ TB Microscopy R24
- ☐ TB Culture >R98

DRUG SUSCEPTIBILITY TESTING:

- ☐ 1st line / Line probe (rifampicin and isoniazid) R176
- ☐ 2nd line R71

FOLLOW UP (only if smear pos after 7 weeks or treatment interuptions)

- ☐ TB GeneXpert R173

TB DATA COLLECTION - MUST BE COMPLETED

SUSPECTED TB (PRE-TREATMENT): DS: drug sensitive DR: drug resistant

Tick all that apply ✓

- ☐ Suspected **DS-TB** (not on treatment)
- ☐ Suspected **DR-TB** (not on treatment)
- ☐ Previously treated for **DS-TB**
- ☐ Previously treated for **DR-TB**

ON TREATMENT (MONITORING): Number of months on treatment

- ☐ **DS-TB** (on treatment) ☐ 2-3 mnths ☐ 4-7 mnths
- ☐ **DR-TB** (on treatment) ☐ 1-3 mnths ☐ 4-7 mnths ☐ > 7 mnths
- ☐ **DS-TB** failing treatment or persistently smear-positive ☐ 2-3 mnths ☐ 4-7 mnths ☐ > 7 mnths

COMMENTS / OTHER TESTS:

PATIENT'S HIV STATUS:

Pos ☐ Neg ☐ Unknown ☐

HIV - SPECIFIC TESTS

HIV DATA COLLECTION - MUST BE COMPLETED

Y ☐ HIV serology R50

If ordering HIV serology, please supply:

Clinic's HIV rapid result (if available): _____

P ☐ CD4 count (PLG) R50

If ordering CD4 count, please tick one category:

- A1 ☐ First ever CD4 count
- A2 ☐ CD4 count taken previously, not yet in ART care
- A3 ☐ In ART care (please mark current drugs)

W P ☐ HIV Viral Load R306

If ordering HIV viral load, please tick one category:

- B1 ☐ First ever viral load (paediatric)
- B2 ☐ Routine monitoring
- B3 ☐ Other (e.g. illness, virological failure)

Months on ARV treatment:

- C1 ☐ Baseline / work-up
- C2 ☐ 6 months
- C3 ☐ 12 months
- C4 ☐ 24 months
- C5 ☐ 36 months
- C6 ☐ Other

Currently off ART due to:

- D1 ☐ Adverse event
- D2 ☐ Non-adherence
- D3 ☐ Toxicity
- D4 ☐ Other

DBS ☐ HIV PCR R342

If ordering HIV PCR, please answer:

Has mother received PMTCT? Yes ☐ No ☐

Has infant received PMTCT? Yes ☐ No ☐

Infant breastfed in past 6 weeks? Yes ☐ No ☐

Current ARV drugs:

- ☐ FDC (Fixed dose combination)
- ☐ AZT ☐ 3TC ☐ EFV
- ☐ ABC ☐ ddI ☐ NVP
- ☐ TDF ☐ d4T ☐ LPV/r
- ☐ Other ARVs: _____

P ☐ HIV Drug Resistance R1872

HIV drug resistance genotype testing **will not be done** if the HIV status, results and treatment questions are not completed.

The DOH has approved HIV drug resistance genotype testing only for certain categories.

If ordering HIVDR, please tick one category and supply results:

- ☐ Baseline testing
- ☐ 1st line failure
- ☐ 2nd line failure
- ☐ 3rd line failure

HIV viral load previous: _____ Date _____

HIV viral load latest: _____ Date _____

Latest CD4 count: _____ Date: _____

Please tick current and previous ARV drugs

According to national ARV guidelines virological failure is defined as 2 consecutive viral loads > 1000 cp/ml at least 2 months apart.

Previous ARV drugs:

- ☐ FDC (Fixed dose combination)
- ☐ AZT ☐ 3TC ☐ EFV
- ☐ ABC ☐ ddI ☐ NVP
- ☐ TDF ☐ d4T ☐ LPV/r
- ☐ Other ARVs: _____

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PLEASE TEAR HERE ... PLEASE TEAR HERE ... PLEASE TEAR HERE ... PLEASE TEAR HERE ...

NATIONAL HEALTH LABORATORY SERVICE

HISTOPATHOLOGY

Practise Number 52

PLEASE PRINT IN BLOCKS AND (✓) THE APPLICABLE BOXES

LOC

CHC / CLINIC	
WARD	
eGK APPROV. CODE	
COPY REPORT TO	

SPEC

SPECIMEN	
ANATOMICAL SITE	
COLLECTION DATE	TIME:
COLLECTED BY	

PATIENT

PATIENT ID NO	ID / Passport
HOSPITAL NUMBER	
SURNAME	
FIRST NAME	SEX M F
DATE OF BIRTH D D M M Y Y Y Y	AGE
RACE	TITLE
PATIENT ADDRESS	
PATIENT TEL NO	HOME WORK
	CELL

CLIN

ICD10 DIAGNOSIS CODES	
Warfarin Heparin	

HCW

CLINICIAN / HCW NAME	
HPCSA / SANC NO	
PRACTICE NO	
CONTACT NO	
EMAIL ADDRESS	
CLINICIAN'S SIGNATURE	

PRIVATE ACCOUNT

AUTHORISATION NO	FEE CLASS:
MEDICAL AID	PLAN:
MEDICAL AID NO	DEP CODE:
MEMBER NAME	
MEMBER ID NO	
MEMBER ADDRESS	
MEMBER TEL NO	
EMPLOYER	
MEMBER'S SIGNATURE	

I consent to tests and take responsibility for payment of th

Inpatient: ☐

Outpatient: ☐

Patient follow-up date: _____

Location of disease (Illustrate below if applicable



Type of Specimen:

- ☐ Routine Processing - Formalin Fixed
- ☐ Election Microscopy
- ☐ Immunoflourescence
- ☐ Frozen Section
- ☐ Other

Nature of Biopsy: Incision ☐ Other: _____

Excision ☐

Biopsy Site: _____

PTO

PLEASE TEAR HERE PLEASE TEAR HERE PLEASE TEAR HERE PLEASE TEAR HERE PLEASE TEAR F

CLINICAL HISTORY, DESCRIPTION

CLINICAL DIAGNOSIS / SUSPICION

OTHER INVESTIGATIONS / INCLUDING IMAGING STUDIES

FBC RESULT/S: (For haematolymphoid specimens)

LFT AND RELEVANT VIRAL SEROLOGY INCLUDING HEPATITIS VIRAL SEROLOGY: **(For liver biopsies)**

HIV:

CD4 COUNT/S (Please indicate relevant dates if applicable):

VIRAL LOAD/S (Please indicate relevant dates if applicated):

HAART REGIME: Yes ☐ No ☐ Date of initiation (if applicable):

DRUG HISTORY:

PLEASE NOTE:

ALL BONE SAMPLES MUST BE ACCOMPANIED BY ALL RELEVANT RADIOLOGICAL / IMAGING FINDINGS WHICH INCLUDES X-RAYS

FOR LABORATORY USE ONLY

Received by	Date Received and Time	Cut up by / Clerker	Spec No

DESCRIPTION	UOM	ORDER QTY
REGIONAL HOSPITALS / 50 SHEETS	40/BOX	100
DISTRICT HOSPITAL / 50 SHEETS	40/BOX	30
PHC REQUEST FORM N1 / 50 SHEETS	40/BOX	160
CYTOLOGY REQUEST FORMS N2 / 50 SHEETS	40/BOX	20
PHC ORDER BOOK N3 / 50 SHEETS	40/BOX	20
PHC FACILITY SPECIMEN REGISTER N4 / 50 SHEETS	40/BOX	20
HISTOPATHOLOGY REQUEST FORM / 50 SHEETS	40/BOX	6

All forms to be barcoded, for tracking purposes
and have the NHLS Logo and practice number, as per below



Practice Number: 5200296