NEW TUBERCULOSIS SUSPECT REFERRAL

Referring Jurisdiction:	Referring Person:	Telephone :
Local Health Department:	Phone:	Fax:
Address:	City/State/Zip:	Date of Referral:

Transferred from Institution: ❒ No ❒ Yes Name of Institution: _____

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ County: _____

Place of Employment: _____Employer Phone: _____

Emergency Contact: _____ Contact Phone: _____

Sex: ❒Male ❒Female **Hispanic:** ❒No ❒Yes **Race:** ❒White ❒Black ❒Asian ❒Am. Indian/Nat. Alaskan ❒Other _____

MEDICAL INFORMATION:

Admission Date: _____/_____/_____ Discharge Date: _____/_____/_____

Admitting Diagnosis: _____ Discharge Diagnosis: _____

Attending Physician: _____ Phone Number: _____

TST Date: _____/_____/_____ Result: _____mm TB Site: _____

Symptoms: _____ Date of Onset: _____/_____/_____

Chest X-Ray Date: _____/_____/_____ Result: _____ CT Scan Date: _____/_____/_____ Result: _____

Mental Health History: ❒No ❒Yes Date Diagnosed: _____/_____/_____ Diagnosis: _____

Drug/Alcohol History: ❒No ❒Yes Date Diagnosed: _____/_____/_____ Diagnosis: _____

BACTERIOLOGY

HIV Test Date: _____/_____/_____

Result: _____

Date of Collection	Specimen type	Smear	Culture	Susceptibility

MEDICATIONS:		**DATE STARTED:**	**COMMENTS:**
ISONIAZID	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
RIFAMPIN	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
PYRAZINAMIDE	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
ETHAMBUTOL	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
PYRIDOXINE	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
_____	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____

Person Completing Form: _____ **Date Completed:** ____/____/____