New Tuberculosis (TB) Suspect Referral

To: _____ County Public Health Department/TB Program
_____ (Local Address)
_____ (City/State/Zip)
Telephone: _____ Fax: _____
From: _____
Date of Referral _____ Referring Person_____ Telephone_____
Transferred from Institution? Yes ___ No ___ Name of Institution_____
Patient Name _____ Race _____ Sex ___ DOB _____
Last First Middle Initial
Address _____
City State ZIP County
Place of Employment _____ Employer Telephone_____
Patient Telephone _____ Emergency Contact_____
Name Telephone

Medical Information:
Admission Date_____ Discharge Date_____ Patient Hospital Room #_____
Admission Diagnosis _____ Discharge Diagnosis _____
Attending Physician _____
Telephone & Pager Numbers
TST _____ mm or IGRA results _____ Date_____ TB Site _____
Symptoms _____ Date of Onset _____
Chest x-ray _____ Date _____ Weight upon Admission/Discharge _____

Bacteriology:

Specimen Type	Source	Date Collected	Results	
_____	_____	_____	Smear _____	Culture _____
_____	_____	_____	Smear _____	Culture _____
_____	_____	_____	Smear _____	Culture _____

Sensitivity Report: _____

Laboratory Results:
AST/SGOT _____ Date _____ HIV _____ Date _____

Medications:
Isoniazid _____mg PO _____ x week Date started: _____ Doses given_____
Rifampin _____mg PO _____ x week Date started: _____ Doses given_____
Pyrazinamide _____mg PO _____ x week Date started: _____ Doses given_____
Ethambutol _____mg PO _____ x week Date started: _____ Doses given_____
Pyridoxine _____mg PO _____ x week Date started: _____ Doses given_____
_____ _____mg PO _____ x week Date started: _____ Doses given_____
_____ _____mg PO _____ x week Date started: _____ Doses given_____

Additional information/Comments (use reverse side of page if necessary):