

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 MI

ADDRESS _____ CITY _____ ZIP _____ COUNTY _____

PLACE OF EMPLOYMENT _____ EMPLOYER TELEPHONE _____

PATIENT TELEPHONE _____ EMERGENCY CONTACT _____

NAME TELEPHONE

MEDICAL INFORMATION:

ADMISSION DATE _____ DISCHARGE DATE _____ PATIENT HOSP. RM. # _____

ADMITTING DIAGNOSIS _____ DISCHARGE DIAGNOSIS _____

ATTENDING PHYSICIAN _____ TELEPHONE & BEEPER NUMBERS _____

TST _____ mm DATE _____ TB SITE: _____

SYMPTOMS: _____ DATE OF ONSET: _____

CHEST X-RAY _____ DATE _____

BACTERIOLOGY:

SPECIMEN TYPE:	SOURCE	DATE COLLECTED	RESULTS
_____	_____	_____	SMEAR _____ CULTURE _____
_____	_____	_____	SMEAR _____ CULTURE _____
_____	_____	_____	SMEAR _____ CULTURE _____

SENSITIVITY REPORT: _____

LABORATORY RESULTS: AST/SGOT _____ DATE _____ HIV TEST _____ DATE _____

MEDICATIONS:

	RESULT	DATE STARTED
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)
_____	_____ MG PO _____ X WEEK _____	(____ doses given)

**ADDITIONAL INFORMATION
 And/or SPECIAL NEEDS:**

COMMENTS: (Please use reverse side of page if necessary)