BEN FRANKLIN TUBERCULOSIS CLINIC

ACTIVE/SUSPECT TB CASE REFERRAL

FAX THIS REFERRAL FORM filled in with a copy of all physician consults and lab results to:
Columbus Public Health Dept, Ben Franklin
TB Control Program, Fax # (614) 645-8669

This is a confidential fax line to the TB program. Please call (614) 645-1823 with any questions.

PATIENT INFORMATION

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

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Parent/Guardian: _____ **Language(s) -** *mark all that apply:* ☐ *English* ☐ *Spanish* ☐ *Other:* _____

Phone: (Home) _____ **(Work)** _____ **(Cell)** _____

Height: _____ ft _____ in **Weight:** _____ lbs

1. CURRENT TUBERCULIN SKIN TEST (TST/PPD) RESULT – *Please indicate mm size of induration*

Size recorded in mm: _____ *mm (induration)* *Date Placed:* ____/____/____ *Date Read:* ____/____/_____ *Provider:* _____

2. PREVIOUS TUBERCULIN SKIN TEST (PPD) RESULT – *Mark one of the following boxes…*

☐ **Prior documented TST** _____ *mm (induration)* *Date Placed:* ____/____/_____ *Date Read:* ____/____/_____ *Where:* _____

☐ **Prior undocumented TST** *(per pt report)* ☐ *Pos* ☐ *Neg* *Date:* _____/_____/_____ *Where:* _____

☐ **Unknown** ☐ **No prior TST (PPD)**

3. TB BLOOD TEST RESULT – *Attach lab report*

Result: ☐ *Neg* ☐ *Pos* ☐ *Indeterminate* *Date:* ____/____/_____

☐ **Quantiferon-TB Gold In-Tube** _____ *IU/ml* ☐ **T-Spot TB**_____ *spot count #*

4. CHEST X-RAY – *Attach a copy of current/prior reports*

☐ **Chest x-ray ordered**: *Date:* _____/_____/_____ *Result:* _____ *Facility Name:* _____

☐ **X-ray result pending** ☐ **X-ray report attached** ☐ **Chest x-ray NOT ordered**

☐ **Sputum ordered**: *Date:* _____/_____/_____ *Result:* _____ *Facility Name:* _____

5. OTHER DIAGNOSTIC TESTING – *Attach a copy of current/prior reports*

☐ **CT scan ordered**: *Date:* _____/_____/_____ *Result:* _____ *Facility Name:* _____

☐ **Bronchoscopy ordered:** *Date:* _____/_____/_____ *Result:* _____ *Facility Name:* _____

☐ **Bronchoscopy NOT ordered** ☐ **CT scan NOT ordered**

6. TREATMENT – *Attach a copy of medical records*

Has a history of prior TB/LTBI diagnosis/treatment? ☐ *No* ☐ *Yes* *If yes, where:* _____ *Date:* _____/_____/_____

Currently under a physicians care for treatment of any acute or chronic illnesses? ☐ *No* ☐ *Yes*

7. SYMPTOMS & RISK FACTORS

Cough:	☐ *No*	☐ *Yes*	*Onset Date:* _____/_____/_____	**Contact to TB case:**	☐ *No*	☐ *Yes*	☐ *Unknown*
Anorexia:	☐ *No*	☐ *Yes*	*Onset Date:* _____/_____/_____	**Foreign Born:**	☐ *No*	☐ *Yes*	☐ *Unknown*
Fatigue:	☐ *No*	☐ *Yes*	*Onset Date:* _____/_____/_____	*If yes, what country?* _____			
Night Sweats:	☐ *No*	☐ *Yes*	*Onset Date:* _____/_____/_____	**Recent travel out of USA for greater than 2 months:**			
Fever:	☐ *No*	☐ *Yes*	*Onset Date:* _____/_____/_____		☐ *No*	☐ *Yes*	☐ *Unknown*
Hemoptysis:	☐ *No*	☐ *Yes*	*Onset Date:* _____/_____/_____	**Homeless (now or Hx of):**	☐ *No*	☐ *Yes*	☐ *Unknown*
Unplanned Weight Loss:	☐ *No*	☐ *Yes*	*#*_____	**IVDU (now or Hx of):**	☐ *No*	☐ *Yes*	☐ *Unknown*
HIV + :	☐ *No*	☐ *Yes*	☐ *Unknown*	**Recent Incarceration:**	☐ *No*	☐ *Yes*	☐ *Unknown*

REFERRED BY:

Contact Name: _____ **Date:** _____/_____/_____

Facility Name: _____ **Facility Address:** _____

Telephone: _____ **Pager:** _____ **Fax:** _____

12/2015

COLUMBUS PUBLIC HEALTH - BEN FRANKLIN TUBERCULOSIS CLINIC
240 Parsons Ave, Columbus OH 43215
Phone: 614-645-1823 / Fax: 614-645-8669
www.publichealth.columbus.gov

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH