Columbus Public Health
Healthier, Safer People

**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)** _____

## 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:** _____

*6/2011*