

# Referral Form for Treatment of Latent TB

Phone: 831-454-4114 FAX: 831-454-5049

**PATIENTS WITH KNOWN OR SUSPECTED ACTIVE TB SHOULD BE REPORTED IMMEDIATELY BY PHONE!**

|   |            |                          |                             |                           |          |
|---|------------|--------------------------|-----------------------------|---------------------------|----------|
| Referring Agency/MD:  |            |                          |                             | Phone:                    |          |
| Address:  |            |                          |                             | Fax:                      |          |
| Client Name:  |            | Date of Birth:           |                             | Age:                      | Sex: M F |
| Address, City, ZIP  |            |                          |                             | Phone:                    |          |
| Country of Origin:  |            |                          | Month/Year Arrived in U.S.: |                           |          |
| Does this patient have medical coverage? Y N If yes, type:  |            |                          |                             |                           |          |
| Note: Non-HSA patients with medical coverage and an established medical home are not typically eligible for LTBI services through HSA.  |            |                          |                             |                           |          |
| TB Skin Test (TST)  | Date Given | Date Read                | Size (mm)                   | Facility Name Reading TST |          |
| Current   |            |                          |                             |                           |          |
| Prior <sup>1</sup>  |            |                          |                             |                           |          |
| Chest X-Ray   | Date:      | Results: (attach report) |                             |                           |          |
| Facility/Provider Performing Chest X-Ray:   |            |                          |                             |                           |          |
| Symptoms: (circle)<br>Cough >3 weeks    Blood in Sputum    Night Sweats    Persistent Fever    Weight Loss    Fatigue    Weakness<br>Call 454-4114 ASAP if you suspect active TB!       |            |                          |                             |                           |          |
| <b>Referrals for LTBI treatment should be made after the results of the patient's x-ray have been received. Please complete the Risk Assessment Scale on reverse side of this form.</b> |            |                          |                             |                           |          |

<sup>1</sup> Prior **documented** TST only, not by patient history.