ERIE COUNTY DEPARTMENT OF HEALTH TB REFERRAL FORM

Attention: Please fax completed form to (814) 451-6767 Call (814) 451-6718 with questions

Patient Information

Patient First Name: _____ Last Name: _____

Patient Address: _____ City _____ State _____ Zip Code _____

Sex ☐ Male ☐ Female DOB _____ Age ____ Parent/Guardian(Under 18) _____

Telephone Number (Include Area Code): _____ SS# _____

Country of Origin: _____ Race _____ Ethnicity ☐ Non-Hispanic ☐ Hispanic

Language Spoken: _____ Needs Interpreter ☐ Yes ☐ No

Referral Information

Origin of Referral: _____ Date Referral Sent: _____

Address: _____ Phone Number: _____

Reason for Referral

☐ Employment Screening ☐ Refugee/Immigrant Screening ☐ Student

☐ Contact to Active TB Specify Name _____

☐ Signs or Symptoms of Active TB disease Date of Onset _____

Describe symptoms: _____

☐ Other (Please specify) _____

TB Test Given

☐ TST/Skin Test ☐ Q Gold ☐ T Spot ***Include Lab report for Q Gold and T Spot including values*

Skin Test Results: Date Placed _____ Date Read _____ Measurement _____mm

CXR Ordered: ☐ Yes ☐ No ***Include copy of report if available.*

If yes, Location: _____ Date: _____

CXR Result ☐ Normal ☐ Abnormal HIV Status (if known) ☐ Reactive/Positive ☐ Non-Reactive/Negative

PCP Information

Primary Care Physician Name: _____

Address: _____ Phone # _____

ECDH Use Only	TB Nursing History Appointment: Date: _____ Time:_____ Follow Up:_____ _____ _____