DENVER PUBLIC HEALTH

Public Health TB Clinic Referral Form

Suspect active TB: Call 303-602-7240

All fields with an asterisk are required to provide the best possible care to our patients.*

Please fax completed form to Denver Metro TB Clinic - 303 602-7263

Reason for Referral? ☐ Work ☐ School ☐ Civil Surgeon LTBI Notification

☐ Other____

Referring Provider?

***Name** ____

***Address** ______________________ ***City** __________ ***Zip Code**__________

***Phone** ______________ ***Fax**_____________ Email ____________________

Patient Information

***Patient Name Last** ____________ ***First** ____________ ***Date of Birth** ________ ***Gender** ____

***Address** __________________ Apt #_____ City _________State ____Zip Code__________

***Patient Contact #:** ____________________ Social Security Number ____________

Country of birth______________***Language** _________________* **Interpreter needed?** Yes ☐ No ☐

***TB Skin Test (TST) Results:**

Date Place: _____ Date Read: _____ Size: ______ (mm)

☐ Positive ☐ Negative

***Please Check One**: ☐ QuantiFERON ☐ T-Spot or ☐ Not done

Date________ Result_________

CXR reading:** ***(Please attach reading)

☐ Normal ☐ Abnormal ☐ Not Done

**** Patient must bring actual CXR film/CD or any other imaging done in the last 6 months to TB appointment.***

If cough, fever, night sweats or weight loss, please call 303-602-7240 before sending this form.

Screening Questions:

1. Symptoms? (please describe) ____
2. Has the patient been given any medications for this condition? ☐No ☐Yes (if Yes, please explain)
3. TB risk factors? ____
4. Any other health conditions or concerns? ____________________________
5. Any lab work? (AFB on any fluids/ tissue, Liver function tests, CBC w/ diff.) (Please attach)____________
6. Medications currently taking (Please attach list) ________________________
7. HIV Status? ☐ Positive ☐ Negative ☐ Unknown