DPHSS-TB REFERRAL FORM

Phone: (671) 788-4098 . Fax: (671) 635-7522
E-mail: TB.Program@dphss.guam.gov

DATE: _____ **REFFERING CLINIC/HOSPITAL:** _____

NAME OF PATIENT: _____ **DOB:** _____

REASON FOR REFERRAL: _____ Phone:

BRIEF HISTORY: _____

_____

Currently on TB Meds? ☐ RIF ____mg / INH ____mg / PZA ____mg / EMB _____mg / Other: _____
Frequency:
Date started TB meds _____ Adverse Rx? ☐ (if yes, explain)
HIV Status: _____ ***Date Done:*** _____

PMH:

Allergies: _____
Medications _____
Med/Surgery: _____

Documents attached:

- ☐ Copy of PPD
- ☐ CXR/CT
- ☐ AFBx3
- ☐ NAAT
- ☐ AFB Culture
- ☐ LFT
- ☐ BIOPSY

include copies of labs

SOCIAL HISTORY:

*ETOH: _____ SMOKE: _____
EMPLOYER: _____ POSITION: _____

INVESTIGATIONS:

(*if done)
PPD DATE GIVEN: ☐ ***PPD DATE READ:*** ☐ ***Measurement:*** ☐ (in "mm")
****IGRA DATE GIVEN:*** ☐ ****LTBI Tx?*** ☐
IGRA RESULT: ☐

CXR FINDINGS: _____ **Date:** _____
CT Result: _____ **Date:** _____
OTHER (biopsies etc…) _____ **Date:** _____

Weight & Height/Date Taken:
Weight: Date:
Height: Date:

SPUTUMS:

#1 _____ **Date:** _____
#2 _____ **Date:** _____
#3 _____ **Date:** _____
NAAT: _____ **Cultures:** _____
(*if available)

***DST:** (if available)

RIF	----------
INH	----------
PZA	----------
EMB	----------

ASSESSMENT/PLAN: _____

_____

_____

*AFB - Acid-fast bacilli *DST - Drug Susceptibility Testing
*NAAT - Nucleic Acid Amplification Testing *LTBI - Latent TB Infection
*LFT - Liver Function Test *IGRA - Interferon Gamma Release Assay
*ETOH - Ethyl Alcohol/Ethanol *PPD - Purified Protein Derivative

_____
PHYSICIAN NAME & SIGNATURE

CHECK LIST FOR HOSPITAL REFERRALS

RULE-OUT ACTIVE TB

To ensure that all clients referred from a hospital to the Department of Public Health and Social Services, TB Control Program receive the appropriate medical evaluation, the following documentation **MUST** be submitted before sending the patient:

- ☐ **Must include a short medical summary**
  - Copy of admission note
  - Copy of History and Physical exam
  - Discharge summary OR discharge note, if summary note available
    - Include problems encountered during admission
    - Key consults

- ☐ **Official Chest X-ray report : 1st and last**

- ☐ **Sputum results for AFB (direct smears x3), and Nucleic Acid Amplification Test (NAAT) from Diagnostic Laboratory Services (DLS). Culture, ID and susceptibility results if available.**

- ☐ **PPD skin test or IGRA**
  - Date of PPD skin test or IGRA given
  - Date of reading/report
  - Result of IGRA or result in "mm" (for PPD only)

- ☐ **HIV Test**
  - Date of HIV test and results

- ☐ **Liver Function Test Result**

- ☐ **Any other pertinent medical/laboratory information that would support/confirm TB diagnosis and treatment**

- ☐ **CT Scan, if done, with results**

Failure to submit all required documents with the referral may delay the patient from receiving the appropriate evaluation and possible treatment.

DEPARTMENT OF PUBLIC HEALTH AND
SOCIAL SERVICES, TB/HD CONTROL PROGRAM
Phone: 671-788-4098/4033 . Fax: 671-635-7522
E-mail: TB.Program@dphss.guam.gov

CHECK LIST FOR CLINIC REFERRALS

RULE OUT ACTIVE TB

To ensure that all clients referred to the Department of Public Health and Social Services, TB Control Program receive the appropriate medical evaluation, the following documentation MUST be submitted before sending the patient:

- ☐ **Referral from the Private Medical Provider**
  - Must include a short medical summary
  - Any other pertinent medical condition
  - Medications the patient is on
- ☐ **Official Chest X-ray report**
- ☐ **Sputum results for AFB (direct smears x3), and Nucleic Acid Amplification Test (NAAT) from Diagnostic Laboratory Services (DLS). Culture, ID and susceptibility results if available.**
- ☐ **PPD skin test or IGRA**
  - Date of PPD skin test or IGRA given
  - Date of reading/report
  - Result of IGRA or result in "mm" (for PPD only)
- ☐ **Liver Function Test Result**
- ☐ **Any other pertinent medical/laboratory information that would support/confirm TB diagnosis**
- ☐ **CT Scan as recommended and results**

Failure to submit all required documents with the referral may delay the patient from receiving the appropriate evaluation and possible treatment.

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