DPHSS-TB REFERRAL FORM

Phone: (671) 687-4388 . Fax: (671) 635-4413

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

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

REASON FOR REFERRAL: _____

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

Form Eff. 12.01.2018

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**
  - Date of PPD skin test given
  - Date of reading
  - Result in mms
- ☐ **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 HEALHT AND SOCIAL SERVICES, TB CONTROL PROGRAM
Phone: 671-687-4388 . Fax: 671-635-4413

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**
  - Date of PPD skin test given
  - Date of reading
  - Result in mms
- ☐ **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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