TUBERCULOSIS PROGRAM/ 1200 EAST FAYETTE ST; BALTIMORE MD 21202/ #410-396-9413; FAX #; 410-396-9403

TUBERCULOSIS REFERRAL FORM

TYPE OF REFERRAL: ☐ **ACTIVE TB** ☐ **LATENT TB INFECTION (LTBI)** ☐ **INDIVIDUALS BEING EVALUATED FOR TB (PRESUMPTIVE TB)**

PATIENT INFORMATION

NAME (First, Last):	ADDRESS (MUST BE RESIDENT OF BALTIMORE CITY)	RACE:
DATE OF BIRTH:	HOME/WORK #:	GENDER: ☐ MALE ☐ FEMALE ☐ NON-BINARY ☐ TRANSGENDER
COUNTRY OF BIRTH:	DATE OF ARRIVAL IN US:	LANGUAGE SPOKEN:

REFERRAL INFORMATION

REFERRED BY:	FACILITY:	PATIENT ADMITTED: ☐ YES ☐ NO	ROOM #
PHONE/PAGER:	FAX:	EMAIL:	PATIENT WEIGHT:

LABORATORY RESULTS

DATE:	QUANTIFERON OR TSPOT	RESULTS: ☐ POSITIVE ☐ NEGATIVE ☐ INDETERMINATE ☐ OTHER ☐ NOT DONE ☐ NEEDS THIS TEST DONE	QUANTITATIVE RESULTS FOR QFT:
DATE PLACED:	SKIN TEST/PPD	DATE READ: RESULTS: ☐ POSTIVE ☐ NEGATIVE	INDURATION IN MM:
DATE:	ALT/AST	RESULTS:	OTHER:
DATE:	HIV	RESULTS: ☐ POSTIVE ☐ NEGATIVE ☐ NOT DONE	CD4 COUNT: VIRAL LOAD:

MICROBIOLOGICAL TESTING

DATE:	SPECIMEN TYPE: i.e. SPUTA, TISSUE	AFB SMEAR:	NAAT TEST:	AFB CULTURE

IMAGING

DATE:	CHEST X-RAY	RESULTS:
DATE:	CT:	RESULTS:
DATE:	OTHER:	RESULTS:

TB STYMPTOMS

☐ COUGH ☐ HEMOPTYSIS ☐ WEIGHT LOSS (HOW MUCH? ________) ☐ FEVER ☐ NIGHT SWEATS ☐ LYMPADENOPATHY ☐ OTHER

TB TREATMENT (IF INITIATED)

DATE:	MEDICATION:	DOSE/FREQUENCY	MEDICATION:	DOSE/FREQUENCY
	ISONIAZID		RIFAMPIN	
	ETHAMBUTOL		PYRAZINAMIDE	

OTHER PAST MEDICAL HISTORY | OTHER NON-TB MEDS

Please fax any relevant radiology and lab reports and nay narrative notes that would aid in our evaluation. Thank you.

SIGNED:____ DATE: ____