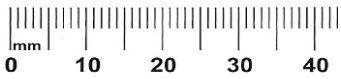
POSITIVE TB SKIN TEST REFERRAL



BALTIMORE CITY HEALTH DEPARTMENT
Division of Clinical Services
Tuberculosis Control Program

Eastern Chest Clinic
620 N. Caroline Street
Baltimore, MD 21205

Phone: 410-396-9413
Fax: 410-396-9403
www.baltimorehealth.org/tb

Patient Name Last First

Birthdate

Address

Zip

Phone

Race ☐ Male ☐ Female ☐ Transgender

Referred by Name Facility

Phone **Email** **Fax**

Insurance Information: Carrier Member #

TB TESTING INFORMATION REQUIRED

TB skin test **Date Placed** _____ **Date read** _____ **Results** _____ **mm** ☐ **Not done**

QTB or T-Spot **Date** _____ **Results** _____

Prior TB test Date Results _____ ☐ **Prior TB Treatment** Details _____

CXR: Date _____ **Results** _____

Signs & Symptoms ☐ **No S/S of TB** ☐ **Cough** ☐ **Night sweats** ☐ **Weight loss** ☐ **Hemoptysis** ☐ **Chest pain** ☐ **Fever** ☐ **Malaise**
☐ **Loss of appetite** ☐ **Lymphadenopathy** ☐ **Other**_____

Risk Factors/Reason for TST:(see http://ideha.dhmh.maryland.gov/CTBCP for Maryland TB Guidelines)

Referral MUST have one of the risk factors listed below. *If patient does not have insurance,* we will mail an appointment to your patient. If patient has no risk factor, or has health insurance, they should be referred to a private physician for evaluation and follow-up.

OUR CLINIC SCHEDULE DOES NOT PERMIT US TO ACCEPT WALK-IN PATIENTS.

☐ **HIV Positive** ☐ **Recent drug use or in Detox Program** **Program Name:** _____

☐ **Immigrant from high incidence country** Country _____ Date in US _____

☐ **Homeless / Staying in homeless shelter in past year** ☐ **in prison/jail in past year**

HIV Date _____ ☐ **Negative** ☐ **Positive** ☐ **Not done** Date _____ **CD4** _____ **Viral Load** _____

HIV Meds ☐ **Yes** ☐ **No** **List:** _____
☐ **HAART**

Relevant past Medical History/Non TB Meds, Comments _____

If available, please fax recent Chest X-Ray report, HIV report and LFT's with referral. Thank you.

Signed _____ **Date** _____