TB SUSPECT/CASE REFERRAL

BALTIMORE CITY HEALTH DEPARTMENT
Health Promotion & Disease Prevention
Tuberculosis Control Program

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

Phone: 410-396-9413
Fax: 410-396-9403

Patient Name _____

Birthdate _____ **Social Security #** _____

Address /Zip _____

_____

Phone

Race _____ ☐ **Male** ☐ **Female** ☐ **Suspect** ☐ **Case** ☐ **LTBI** **Site:** _____

Birth Country _____ **Date in US** _____

Emergency Contact *Name* *Address* *Phone*

Referred by _____ **Facility** _____

Phone _____ **Pager** _____ **Fax** _____

Admission Date **D/C Date** **Room#** **Patient ID**

PPD: **Date placed** _____ **Results MM** _____ ☐ **Prior +** **LTBI** _____ ☐ **Not done**

CXR: Date _____ **Results** _____

Chest CT: Date **Results**

Signs & Symptoms

Duration_____

☐ **No S/S of TB** ☐ **Cough** ☐ **Hemoptysis** ☐ **Night sweats** ☐ **Chest pain** ☐ **Fever** ☐ **Malaise**
☐ **Loss of appetite** ☐ **Weight loss - How much** _____ ☐ **Lymphadenopathy**
☐ **Other** _____

Bacteriology

Date	Specimen	AFB Smear	Culture	Sensitivities	Lab	Date	Result
					ALT		
					AST		
					T-Bili		
					Creatinine		
					Alk Phos		

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

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

TB TREATMENT **Patient Weight** _____ **Allergies** _____

Date	Medication	Dose/Frequency	Date D/C	Recommendations (Date)
	Isoniazid			
	Rifampin			
	Pyrazinamide			
	Ethambutol			

Past Medical History/Non TB Meds _____

Signed _____ **Date** _____

☐ **REQUEST LABS, BACTERIOLOGY, CXR/CT REPORT, ADMISSION/DC SUMMARY TO BE FAXED!**