HAMILTON COUNTY PUBLIC HEALTH

PREVENT. PROMOTE. PROTECT.

HCPH TB Clinic Referral

***Date: _____**

***Reported By: _____ *Phone: _____**

***Hospital: _____**

***Type of referral: ____ Active/Suspect TB _____Positive skin test/QFT(mark results below) ____ LTBI**

Patient Information:

***Patient's Name: _____ *MRN: _____**

***DOB: _____**

(If this is a hospital referring, you must provide all the above information marked with *) All other facilities please provide all information marked with * and as much information as possible listed below. Lab report required for QFT.

Mantoux TST results: _____ mm Date of Mantoux TST: _____ Date Read: _____

Date of IGRA: _____ IGRA Interpretation: _____

Patient's Address: _____

_____

Phone: _____

Country of Origin: _____Date Arrived in US: _____

Primary Language: _____ Requires Interpreter: ___ Yes ___ No

Race: _____ Ethnicity: ____ Hispanic or Latino ____ Not Hispanic or Latino

Name of Insurance: _____

Member ID: _____

Name of Spouse, Guardian, Sponsor, Institution: _____

Patient's Employment: _____

Patient's School: _____

Other Risk Factors/Notes: _____

_____

If you suspect this patient is infectious, please call 513-946-7975 NOW! Please fax this referral and any results to 513-946-7603. Have LTBI patients call 513-946-7610 to schedule an appointment. If this patient does not call to schedule an appointment within 10 days, you will be notified by letter.