

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

Patient Name	Last _____	First _____
Birthdate	_____	Social Security # _____
Address	_____	
Zip	_____	
Phone	_____	
Race	<input type="checkbox"/> Male <input type="checkbox"/> Female	

Referred by _____ **Facility** _____

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

TST Info Required	Date Placed _____	Date read: _____	Results _____ mm	<input type="checkbox"/> Not done
Prior TST	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date/Results _____	<input type="checkbox"/> Prior TB Treatment	Details _____
CXR: Date	_____	Results	_____	
Chest CT: Date	_____	Results	_____	
Signs & Symptoms	<input type="checkbox"/> Cough <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Night sweats <input type="checkbox"/> Chest pain <input type="checkbox"/> Fever <input type="checkbox"/> Malaise <input type="checkbox"/> No S/S of TB <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Weight loss: How much _____ <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Other _____ Duration _____			

Referral must have one of the risk factors listed below. TST must be ≥ 10mm
We will mail an appointment to your patient, if they meet our criteria. We CAN NOT take walk-in patients.

Risk Factors/Reason for TST: (see <http://edcp.org/tb> for Maryland TB Guidelines)

HIV Positive (TST+ ≥ 5mm) Recent injecting/non-injecting drug use/Detox Program: _____
 Documented recent negative skin test (less than 2 years): Date: _____ Results _____
 Recent (< 5 years) immigrant from high incidence country: _____ Date in US _____
 Child < 16 years old Dialysis - Days: M, W, F Tu, Th, Sat
 Homeless shelter/homeless in past year Prison/jail in past year

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

HIV Yes No **List:** _____

Meds HAART

TLTBI TREATMENT		Patient Weight	Where begun	
Date	Medication	Dose/Frequency	Date D/C	Comments
	Isoniazid			
	Rifampin			

Relevant past Medical History/Non TB Meds, Comments _____

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

Signed _____ **Date** _____