

MAINE TUBERCULOSIS CONTROL PROGRAM PREVENTIVE TREATMENT REFERRAL

PHONE: 207-287-8157

FAX: 207-287-6865

CLIENT NAME: _____

DOB: _____

SEX: M F

Address: _____

Home Phone Number: _____

Country of Birth: _____

Language: _____

Parent's Name: _____

Patient Weight: _____

kg

(If patient is under 15 years of age)

If student, is the health center nurse aware of referral?

Yes No

Race: White Black American Indian/Alaskan Asian/Pacific Islander

Ethnicity: Hispanic Non-Hispanic

Reason testing done:

HIGH RISK

CONVERTER

FOREIGN BORN

CONTACT

CHILD UNDER AGE 15

IMMUNOCOMPROMISED

CONGREGATE SETTING

SUBSTANCE ABUSE

OTHER : _____

Mantoux TST	Date:	Results:	mm	
Previous TST	Date:	Results:	mm	
IGRA	Date:	Results:	mm	Specify IGRA Test:
Chest x-ray	Date:	Results: N <input type="checkbox"/> Abnormal <input type="checkbox"/>		If abnormal x-ray, describe:
Liver Function Tests? Y <input type="checkbox"/> N <input type="checkbox"/>		Results: N <input type="checkbox"/> Abnormal <input type="checkbox"/>		Date: AST: ALT:

HIV Status: Known? Yes No Hepatitis? Yes No Chronic Renal Failure? Yes No
 Homeless? Yes No Pregnant? Yes No Pulmonary silicosis? Yes No
 Injection Drug Use? Yes No Diabetes mellitus? Yes No Gastric by-pass Yes No
 Leukemia/lymphoma? Yes No Cancer of head/neck? Yes No

Prolonged high-dose steroid therapy or other intensive immunosuppressive therapy? Yes No

Prescribing Physician: _____ MD DO Primary Care Provider: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

DRUG REQUEST Daily Bi-Weekly DOPT **ORDER DATE** **DURATION OF TREATMENT**

ISONIAZID: _____ mg _____
 RIFAMPIN: _____ mg _____
 PYRIDOXINE (B6): _____ mg _____

COMMENTS: _____

Person Referring: _____ Date: _____

For TB Control Use Only
 Date Received by TBC _____
 Date/Time Faxed to PHN Central Referral _____ (Sender) _____
 Date/Time Called to PHN Central Referral _____
 Date confirmed PHN enrollment _____ Nurse Assigned _____
 Date started meds _____ Date completed meds _____
 Comments _____
 ARS 11/8/11

Pharmacy

Pharmacy Name _____
 Phone # _____

Pharmacist Name _____
 Pt. ID # _____