

MAINE TUBERCULOSIS CONTROL PROGRAM REFERRAL FORM

SUSPECT/CASE

Pulmonary: Airborne Precautions: Yes No X-Pulmonary:

CLIENT NAME: _____ D.O.B.: ___/___/_____ SEX: M F

ADDRESS: _____ CLIENT PHONE NUMBER: _____

PLACE OF BIRTH: _____ D.O.E.: ___/___/_____

PARENTS: _____ LANGUAGES SPOKEN: _____

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

Ethnicity: Hispanic Non-Hispanic

Hospitalized?: No Yes If yes where? _____ Admission Date: ___/___/___ Discharge Date: ___/___/___

TST: Was Mantoux (PPD) Done? No Yes Date: ___/___/___ Results: _____ mm

Previous TST Done? No Yes Date: ___/___/___ Results: _____ mm

Was **Chest X-ray** Done? No Yes Date: ___/___/___ Results: (N/Abn) _____

CT Scan Yes No Date ___/___/___ Result: _____ Cavitary Yes No Miliary Yes No

HIV Status: Known Unknown **Substance Abuse:** Yes No **Congregate Living:** Yes No

Homeless: Yes No

Were Liver Function Tests Done? No Yes Results: ALT _____ AST _____

Specimen Type: _____ AFB Results: _____ Culture Results: _____

Date Collected: _____ Date Reported: _____ Probe Done: Yes No

Was sputum or specimen sent to Maine CDC Health & Environmental Testing Laboratory? Yes No

Susceptibility Testing Done: Yes No Results: _____

<u>Drug Request</u>	<u>Order Date</u>	<u>Start Date</u>	<u>Termination Date</u>
Isoniazid: _____ mg	___/___/___	___/___/___	___/___/___
Ethambutol: _____ mg	___/___/___	___/___/___	___/___/___
Pyridoxine: _____ mg	___/___/___	___/___/___	___/___/___
Rifampin: _____ mg	___/___/___	___/___/___	___/___/___
Pyrazinamide: _____ mg	___/___/___	___/___/___	___/___/___
D.O.T.: Daily <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Number of weeks _____			

Symptoms

Cough: No Yes Onset: ___/___/___

Unexplained weight loss: No Yes

Current Weight ___ lbs/kgs

Lost: ___ lbs/kgs

Normal Weight: ___ lbs/kgs

Appetite Loss No Yes

Fever: No Yes

Chills: No Yes

Fatigue: No Yes

Night Sweats: No Yes

S.O.B.: No Yes

Chest Pain: No Yes

Contact to TB? No Yes Unknown

Medical History

BCG vaccine given? No Yes

What age? _____

Previous TB treatment: No Yes

How long? _____

When? _____ TB medicine: _____

Current medication: _____

Medication allergies: _____

Chronic illness or immune problems: No Yes

What kind? _____

Pregnant: No Yes Maybe

Hepatitis No Yes What type:

Hepatitis A Hepatitis B

Hepatitis C Unknown

TB Education provided? Yes No

Primary Care Physician: _____ MD ___ DO ___ Phone Number: _____

Address: _____

Person Referring: _____ Date: ___/___/___

Specialist/Consultant: _____ / _____

Telephone # _____

TB Clinic appointment: ___/___/___

Called into Public Health Nursing: No Yes Date: ___/___/___

For TB Control Use Only

Referral Sent To: _____

Date Sent: _____ By Whom: _____

Nurse Assigned: _____

Pharmacy

Pharmacy Name _____

_____ Phone # _____

Pharmacist Name _____

Pt ID# _____

Notes: _____
