A picture containing whiteboard

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**Southern Minnesota**

**Virtual TB Consultation Form**

**Instructions:** Please complete form below, including patient demographic information, clinical question, and relevant patient clinical information.

**Send completed form to:** Encrypted Email:  [publichealthreferrals@co.olmsted.mn.us](mailto:publichealthreferrals@co.olmsted.mn.us)      OR

Fax: (**507) 328-7501**

1. **Patient information** (information used to assign patient a Mayo Clinic number to store consultation information for future / follow-up provider correspondence).
   1. Patient Name:
   2. Date of Birth:
   3. Home Address of Patient:
2. **Contact information of requesting health provider:**
   1. Name and organization / title:
   2. Contact information where we can reach you:

* Phone number:
* Email address:

1. **Clinical question and relevant patient clinical information**
   1. Clinical question:
   2. Relevant supporting clinical information, include attachments (if available/needed)