

**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      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)