Olmsted County TB Clinic Referral Form

Last name: ____________________ First name: _____________________ DOB: ______________

Address: ___________________________ Telephone (____) ____- ___-__ Age: _______ Sex: ☐M or ☐F

Language: _____________________________

Mayo Clinic #: _________________ Primary Provider:__________________________________

Current TB Symptoms:

☐Cough ☐Hemoptysis ☐Night sweats ☐Fever ☐Chest pain ☐Fatigue ☐Anorexia/Wt loss ☐Hoarseness ☐ None

☐Other____

History of:

- TB Exposure: ____ BCG: ____________________
- Previous TB Tx (Infection/Disease): _________When: __________Where: ____________________
- Meds/Duration:____

Current:

- TST: Date: ________ Result: ______________________ Reason for TST: ___________________
- CXR: Date: ________Result: _______________________ Where: __________________________
- QuantiFERON or T-spot: Date: ________ Where: ___________________________

Health Concerns: ☐Seizure ☐Diabetes ☐Polyneuropathy ☐Renal Insufficiency ☐Malnutrition

History of Liver Disease/Hepatitis: Yes No Type: ____

Substance Use: ETOH (Prst/Past) Yes No IV Drug (Prst/Past) Yes No

Tobacco (Prst/Past) Yes No Additional info: ____

Pregnant __________ LMP:_________ Breastfeeding __________ Post-Partum ______________

HIV Status ___________________ Date of last test: ______________

Drug Allergies ____

Current Medications: ____

Other pertinent info: ____

Please return completed form to publichealthreferrals@olmstedcounty.gov or fax to 507-328-7501 Attn: TB Clinic along with lab results and chest x-ray results. Valid chest x-rays are within the last 3 months.

** TB CLINIC STAFF TO FILL OUT BELOW **

Date of referral: ___________________________ Referred by: __________________________________

Date Nurse reached client: ________________________________

Country of Birth:____

If born outside of U.S., date arrived in U.S.____________ Date arrived in Olmsted County ____________

Additional info: ____

Past Medical/Family/Social History:

Travel Plans____

Physical Exam:

- T _________ B/P __________ Pulse ________ Wt. ________
- General:
- Lymph:
- HEENT:
- Chest/Lung:
- Cardiac:
- Abdomen:
- Extremities:
- Neurologic:
- Skin:

Diagnosis: (TB Classification)

__ Class 1a TB exposure, not infected
__ Class 1b TB exposure, initial TST negative
__ Class 2 TB exposure, no disease (LTBI)
__ Class 3a Pulmonary TB, clinically active
__ Class 3b Extra-pulmonary TB, clinically active (site: ______________________________)
__ Class 4 TB, not clinically active
__ Class 5 TB disease suspected
__ Other diagnosis (specify) ____

Plan:

Physician ____ Date: __________________