GOVERNMENT OF THE DISTRICT OF COLUMBIA
# Department of Health

# Tuberculosis (TB) Control Program Referral Form

Date:_____

***Please fill out the form completely. Patients may not be seen if the form is not complete.***
***A CHEST X-RAY FILM MUST ACCOMPANY THE PATIENT***

Referring Clinic or Agency:_____
Referring Physician or Nurse Practitioner:_____
Address:_____ Telephone:_____
_____ Fax:_____

Patient:_____ DOB:_____
Address:_____ Telephone:_____
_____

**Reason for Referral:**

☐ New positive TB skin test (PPD) Date Placed:_____ Date Read:_____
Measurement in (mm) _____ ("positive" is not acceptable; must have a measurement)

☐ Clearance for previously positive TB skin test (PPD) Year of conversion:_____
Previous treatment with TB medication: ☐ Yes ☐ No
Date and location of last Chest x-ray:_____

☐ Other: _____
_____

Comments:_____
_____
_____

Signature of Referring Physician or Nurse Practitioner:_____

Date:_____

***Please contact the clinic (202)698-4040 and request to speak with a nurse or physician if the clinic is closed and the referral is urgent.***

1900 Massachusetts Ave. S.E.* Bld. 15, Washington D.C. 20003 * Tele: 202-698-4040 * Fax 202-724-2363

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## Tuberculosis (TB) Control Program Risk and Symptom Assessment Form

If the patient, who presents with signs/symptoms consistent with TB, answers yes to any question in either assessment, please complete the TB Control Program referral form and refer the patient to the Chest Clinic for medical evaluation.
**The referral form and a chest x-ray film must accompany the patient.**

### Risk Assessment:

☐ Yes ☐ No: Current close contact with a known or suspected TB disease case
☐ Yes ☐ No: Diabetic
☐ Yes ☐ No: Kidney Failure /Dialysis
☐ Yes ☐ No: Immunocompromised, i.e. HIV disease, (please send copy of HIV test and CD4 results), chemotherapy, etc.
☐ Yes ☐ No: From a high risk setting (substance abuse, homelessness, shelter living, recent incarceration)
☐ Yes ☐ No: Arrived in the USA in last five years from a country where TB is common
☐ Yes ☐ No: Cancer of the head or neck
☐ Yes ☐ No: Gastric or intestinal bypass surgery
☐ Yes ☐ No: On immunosuppressive therapy (such as "steroids" ≥ 15mg/d for ≥ one month or on Remicade or Humira)

### Symptom Assessment:

☐ Yes ☐ No: Cough lasting 2 to 3 weeks
☐ Yes ☐ No: Hempotysis
☐ Yes ☐ No: Night sweats (night clothes are wet)
☐ Yes ☐ No: Loss of Appetite
☐ Yes ☐ No: Unexplained weight loss
☐ Yes ☐ No: SOB
☐ Yes ☐ No: Unexplained fever
☐ Yes ☐ No: Unexplained fatigue
☐ Yes ☐ No: Lymphadenopathy

Name and Signature of Healthcare Provider Completing Assessments: _____

Date: _____

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