Tuberculosis Referral Form

Cover Sheet

1. Referring Organization

Name of referring organization: _____

Contact name: _____ **Contact phone:** _____ **Contact fax:** _____

Date sent: _____ **Time sent:** _____ ☐ am / ☐ pm **Number of pages (with cover sheet):** ____

2. Receiving TB Clinic

Pick which TB Clinic the referral is for. Only pick one TB Clinic.

County	State Service Center	Fax number
☐ New Castle	Floyd I. Hudson	302-283-7564
☐ Kent	James W. Williams	302-857-5131
☐ Sussex	Thurman Adams	302-515-3201

Instructions

Read all the instructions. After reading the instructions, add the information requested on pages 1-2.

***If you are referring someone for tuberculosis infection (TBI) follow-up**, complete the form and fax it to the appropriate tuberculosis clinic: 302-283-7564 (New Castle County), 302-857-5131 (Kent County), 302-515-3201 (Sussex County). A positive interferon-gamma release assay (IGRA) or tuberculin skin test (TST) are required to refer someone to the Division of Public Health tuberculosis clinics for TBI follow-up.*

***If you are referring someone for tuberculosis disease follow-up**, immediately contact the Office of Infectious Disease Epidemiology (OIDE) to report the case. Health care personnel must rapidly report suspected (i.e., without waiting for laboratory confirmation) and confirmed cases of TB disease to the OIDE. Cases can be reported by phone (302-744-4990, normal business hours; 1-888-295-5156, outside of normal business hours), fax (302-622-4149), or email reportdisease@delaware.gov.*

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

COMMUNITY HEALTH SERVICES

Tuberculosis Referral Form

1. Patient Information

Patient name: _____ **Date of birth:** _____

Primary contact: ☐ Self | ☐ Parent / guardian / other **If parent / guardian / other, who?** _____

Patient address: _____ **Phone:** _____ **2nd Phone:** _____

Country of birth: _____ **Interpreter needed?** ☐ Yes | ☐ No **Preferred contact method:** ☐ Call ☐ Text

Date arrived in US: _____ **If interpreter needed, what language?** _____

2. Medical Information

Include copies for applicable laboratory reports (e.g., IGRA, skin test) and radiology (e.g., chest x-ray).

☐ **TST** Size (mm): _____ Date placed: _____ Date read: _____

IGRA ☐ QFT | ☐ TSpot Result: _____ Date collected: _____ Date reported: _____

Chest x-ray status ☐ Completed | ☐ Incomplete / Pending If completed, date of study? _____

Symptom screen

Symptom	*Onset date*
☐ Cough	_____
☐ Hemoptysis	_____
☐ Chest pain	_____
☐ Fever	_____
☐ Sweating at night	_____
☐ Weight loss	_____

Medical history

Current weight: _____ ☐ lbs / ☐ kg (select unit)

HIV status? ☐ Positive | ☐ Negative

Pregnant? ☐ Yes | ☐ No If yes, delivery date? _____

Significant medical history? ☐ Yes | ☐ No If yes, explain in notes.

Medication history

TB treatment history? ☐ TB infection | ☐ TB disease

Vaccinations in last 28 days? ☐ Yes | ☐ No

Current medications? ☐ Yes | ☐ No

If yes to any, explain in notes.

3. Notes

Use this section to explain the patient's medical history, TB treatment history, vaccinations received in last 28 days, and current medications (include dosage and frequency). Include another page if additional space needed to explain history.

_____

_____

_____