GCHD
GRANT COUNTY HEALTH DISTRICT

TB Services Referral

Fax completed form to 509-764-2813
Questions? 509-766-7960 x 13

Date: _____ **Interpreter Needed** **Yes** ☐ **No** ☐

Patient's Name: _____ **Birthdate:** _____

Parent or Guardian (if patient is a minor) _____ **Phone #** _____

Physical Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Positive TB test documentation for TST OR IGRA

Referred by (name of health professional/doctor/clinic or another agency referring patient**):**

_____ **Phone:** _____

Date of TST: _____ **Time Give:** _____ **Given by:** _____

Date Read: _____ **Time Read:** _____ **Results (mm's):** _____ **Read by:** _____

IGRA results: _____**Date:** _____

Reason for TB testing:

- ☐ **Exposure to an active TB Case**
- ☐ **School Migrant Program Screen**
- ☐ **Substance Abuse Screen**
- ☐ **Prenatal Screen**
- ☐ **If Pregnant EDC** _____
- ☐ **Immigration Physical**
- ☐ **Employment**
- ☐ **Childcare/Foster Care**
- ☐ **Health Care Worker**
- ☐ **Other** _____

SYMPTOMS (Check Any That Apply)

- ☐ **Cough**
- ☐ **Fever**
- ☐ **Chest Pains**
- ☐ **Loss of Appetite**
- ☐ **Weight Loss**
- ☐ **Night Sweats**
- ☐ **Fatigue**
- ☐ **None**
- ☐ **Other (Please Describe)** _____

If facility or employer is paying for the TB consult, please indicate that by signing financial responsibility below:

Send bill to: _____

Financial responsibility signature: _____

**********For GCHD Office Use Only**********

Comments: _____

PHN Alerted: Yes ☐ _____ **No** ☐ **Referral Received by (**initials**)** _____ **Date:** _____
name

Reviewed by PNH (name/title): _____ Date: _____