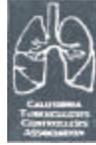


# CALIFORNIA CONFIDENTIAL TB REFERRAL FORM

TO:



FROM:

*Our Department has received information that the following client resides in your health jurisdiction*

Type of Referral:	<input type="checkbox"/> TB Suspect	<input type="checkbox"/> TB Case	<input type="checkbox"/> Contact	<input type="checkbox"/> Source Case Finding	<input type="checkbox"/> Converter
	<input type="checkbox"/> Reactor	<input type="checkbox"/> Other:		<input type="checkbox"/> Initial Report	<input type="checkbox"/> Update

Name (Last, First, M.I.)	AKA	Age/DOB	Social Security #	Sex
Head of Household (Name)	Language	Bilingual? Yes No	Race/Ethnicity	Occupation
Present Address (P.O. Box, General Delivery, or Star route, give locating directions)			Phone	
Previous Address			Booking #	Cal. Dept. Correction #
Physical Description (Height, Weight, Hair Color & Style), Scars, Tattoos, or Glasses, etc.			RVCT Sent to State: <input type="checkbox"/> No <input type="checkbox"/> Yes, date _____	
			Calif. RVCT TB Case# _____	

**CLINICAL INFORMATION for:**

1. <input type="checkbox"/> Person being referred	2. <input type="checkbox"/> Index case for contact/source case finding
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CXR		BACTERIOLOGY		
Impression	Specimen Date	Specimen Type	Results	
			Smear	Culture

Skin Test Results		Symptoms	Major Site of Disease	Sensitive to All Drugs
Date	Results (mm)	Date onset _____ <input type="checkbox"/> Cough <input type="checkbox"/> Productive Sputum <input type="checkbox"/> Other _____	<input type="checkbox"/> Pulmonary <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No, attach lab report(s).

**CHEMOTHERAPY:**

Drug/Dose	Dated Started	Date D' Ced	# Given	ADHERENCE
Isoniazid				<input type="checkbox"/> Yes
Rifampin				<input type="checkbox"/> No, Explain _____
Ethambutol				
PZA				DOT
Other				<input type="checkbox"/> No
Other				<input type="checkbox"/> Yes (Daily/Biweekly)

**Return Disposition Requested:**  No  Yes

<p><b>DISPOSITION:</b></p> <p><input type="checkbox"/> Located</p> <p><input type="checkbox"/> Not Infected      <input type="checkbox"/> Under care</p> <p><input type="checkbox"/> Previously treated      <input type="checkbox"/> Refused follow-up</p> <p><input type="checkbox"/> Moved (see comments)      <input type="checkbox"/> Died, date: / /</p> <p><input type="checkbox"/> Unable to locate</p>	<p><b>COMMENTS:</b></p> <p>Completed by: _____</p> <p>Title: _____</p> <p>Tel.#: _____ Date: / /</p>
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**CONTACT/SOURCE CASE FINDING ONLY:**

Name of Index Case _____	
RVCT# of Index Case (If applicable) _____	
Relationship to Index Case _____	
Evaluate the following household/close contacts:	
Name	DOB/Age

**RISK FACTORS:**

Check any of the following risk factors if present:

Index case	Person being referred	<input type="checkbox"/> Immunosuppressed <input type="checkbox"/> Injecting drug user <input type="checkbox"/> Abnormal chest x-ray c/w old TB <input type="checkbox"/> Foreign born from high prevalence country <input type="checkbox"/> Under 6 years of age <input type="checkbox"/> Other medical risk factors (Specify): _____
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**RECOMMENDATIONS:**

<input type="checkbox"/> Skin test	<input type="checkbox"/> Start INH
<input type="checkbox"/> Chest x-ray	<input type="checkbox"/> Continue INH

Other: \_\_\_\_\_

**PROVIDER:**

Name: \_\_\_\_\_

Tel.#: \_\_\_\_\_

**REMARKS:**

See Attached

**COMPLETED BY:**

Completed by: \_\_\_\_\_

Title: \_\_\_\_\_

Tel.#: \_\_\_\_\_ Date: / /

*Figure 8.13 Sample referral form used by California. California Department of Health Services, Division of Communicable Disease Control, Tuberculosis Branch. California Inter-jurisdiction Referral Desk Protocol; 1999.*