PUBLIC HEALTH INSTITUTE AT DENVER HEALTH™

Tuberculosis Clinic Referral Form

Complete all sections and fax to the Tuberculosis Clinic - 303 602-7263

Referring Provider

Name _____

Address _____ City _____ Zip Code_____

Phone _____ Fax_____ Email _____

Patient Name Last _____ First _____ Date of Birth _____

Address _____ Apt #_____ City _____State _____ Zip Code_____

Best number to contact patient _____ Male:☐ Female☐ Social Security: _____

Country of birth_____Language _____ Interpreter needed? Yes☐ No☐

1. Please check if the patient is experiencing any of the following symptoms. **If more than one symptom box is checked, call the TB Clinic before sending the referral at (303) 602-7240.**

☐ Weight Loss ☐Cough ☐Night Sweats ☐Loss of Appetite ☐Fatigue ☐Fever ☐None

2. Tuberculosis Risk Assessment

☐ Birth or foreign travel of > countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
☐ Immunosuppression, current or planned
☐ Close contact to someone with infectious TB at any time

Fax results for QFT/TSPOT/PPD tests with the referral. If applicable, also send results for HIV test and liver function.

Please Check One: ☐Quantiferon ☐T-Spot ☐Not done ☐TB Skin Test

☐ Patient bringing CXR to Clinic
☐ CXR being sent through PACS
☐ CXR not done

(11/2021)