Boston Public Health Commission, TB Clinic
BMC, Preston Family Building 5th Floor
732 Harrison Avenue, Boston MA 02118
Appointments: (617) 534-4967
Nurse Triage: (617) 534-4875
Fax: (617) 534-4976

TB Clinic Referral Form

Referring Agency

NAME OF AGENCY: _____

ADDRESS: _____ CITY: _____ ZIPCODE: _____

CONTACT NAME: _____ PHONE: ( ) _____ FAX: ( ) _____

Patient Information **Please print clearly**

PATIENT NAME, LAST: _____ FIRST: _____ MIDDLE: _____

ADDRESS: _____ APT #: _____ CITY: _____ STATE: _____ ZIPCODE: _____

PHONE: ( ) _____ 2ND PHONE: ( ) _____ GENDER: MALE FEMALE

MARITAL STATUS: _____ SSN: - - DATE OF BIRTH: / /

COUNTRY OF BIRTH: _____ INTERPRETER NEEDED? YES NO IF YES, LANGUAGE: _____

PATIENT SEEN AT BMC BEFORE? ☐ YES ☐ NO IF YES, BMC RECORD # _____

DOES PATIENT HAVE HEALTH INSURANCE? ☐ YES ☐ NO

CARRIER: _____ POLICY #: _____ AUTHORIZATION # FOR VISIT: _____

TST Results & Medical History

TUBERCULIN SKIN TEST (TST): SIZE: _____ (MM) DATE READ: _____ / _____ / _____

IF YOU ARE REFERRING A PATIENT WITH A POSITIVE IGRA, WE REQUIRE A COPY OF THE LABORATORY REPORT.

PLEASE SUBMIT CURRENT PROBLEM LIST & ALL CURRENT MEDICATIONS ON SUPPLEMENTAL FORM OR IN ATTACHMENT:

☐ NO CURRENT MEDICATIONS ☐ NO SIGNIFICANT MEDICAL HISTORY

Appointment Scheduling Information

Please mark 1st, 2nd, and 3rd choice for appointment DAY. The appointment TIMES will be within the hours listed. The visit requires at least 2 hours to complete the process, including MD exam, chest x-ray, and laboratory work.

A PARENT MUST ACCOMPANY ALL PATIENTS UNDER 18 YEARS OF AGE.

___ MONDAY: 1:00—3:00 ___ WEDNESDAY: 1:00—3:00 ___ FRIDAY: 8:30—11:00

___ TUESDAY: 8:30—11:00 ___ THURSDAY: 8:30—11:00

To be completed by BPHC TB Clinic only:

The following patient has an appointment in the TB clinic. Please notify the patient. Thank you.

BMC MED REC#	APPT. DATE	DAY	TIME

Appointment not scheduled because of the following missing information: (check all that apply)

☐ TST (SIZE & DATE) ☐ DOB ☐ ADDRESS ☐ INTERPRETER ☐ OTHER: _____

Clinical Information

_____
(Patient Name) (Date of Birth)

The BPHC TB Clinic has received a request for an appointment the patient referenced above.
To schedule an appointment, the following information is needed:

☐ **TUBERCULIN SKIN TEST (MANTOUX, PPD):**

The **size** of the TST is critical in determining appropriate treatment. The TB Clinic no longer accepts a patient's verbal report of a positive reaction. For all patients with an undocumented history of a "positive" TST, **a repeat TST must be done or approval given by the TB clinic allowing for exclusion** prior to receiving an appointment. Please contact the clinic triage office at (617) 534-4875 to discuss any patient or provider concerns.

SIZE _____ (MM INDURATION) DATE READ _____

☐ **MEDICAL PROBLEM LIST**

1._____ 5. _____
2._____ 6._____
3._____ 7._____
4. _____ 8._____

☐ **No significant medical history**

☐ **CURRENT MEDICATIONS (DOSAGE AND FREQUENCY)**

1._____ 5. _____
2._____ 6._____
3._____ 7._____
4. _____ 8._____

☐ **No current medications**

For persons with suspected TB disease, please provide information on any chest radiographs or CT scans performed since the time of symptom onset:

DATE: _____ TEST LOCATION: _____

RESULT: _____

PRIMARY CARE PROVIDER INFORMATION

NAME _____ PHONE # _____

PAGER # _____ FAX # _____