# Outpatient Rule-Out Tuberculosis Referral Form

Please Type or Print Legibly

| Client's Name (Last, First MI) | Date of Birth (mm/dd/yy) | Social Security Number |
|---|---|---|
| | | |

| Parent/Guardian Name (minors) |
|---|
| |

| Telephone Number | Home Address (no P.O. Boxes) | City | State | Zip |
|---|---|---|---|---|
| | | | | |

Referred To: **Bay County Health Department TB Program** **Fax: 850-747-5475** **Phone: 850-872-4720x1300**

Address: **597 W. 11th Street, Panama City, FL 32401**

| From (name of person making referral) | Fax Number: | Telephone Number: |
|---|---|---|
| | | |

Office Name:

Office Mailing Address:

Reason for Referral/Notes to Referral Agency: *Patient does not meet admission criteria for inpatient rule-out TB protocol. Please rule-out TB as an outpatient. To minimize community exposure, the patient has been instructed NOT to go to the health department, but to stay at home until contacted by health department TB staff.*

**I understand this referral will result in all six of the following services being performed:** **1) In-home evaluation 2) At-home isolation** 3) QFT-Gold **4) Chest X-ray 5) Sputum for AFB daily x 3 6) Start 4-drug therapy**

______________________________________________
Referring Physician's Signature Date

Response to Referral Originator: Client contacted by BCHD staff on ____________________.
(Date)

- ○ Evaluation determined no intervention needed
- ○ LTBI therapy started
- ○ Therapy for active TB initiated

______________________________________________
BCHD TB Program Representative's Signature Date

Original mailed to doctor's office _______________ by _________________________________.
Date Signature

DH 5065 (revised by BCHD Lcpwct{ '4234)