

Referral Form For Treatment of Latent TB

Santa Cruz County ~ Communicable Disease (CD) Unit

Phone: (831) 454 - 4114

After Hours: (831) 471 - 1170

Fax: (831) 454 - 5049

PATIENTS WITH KNOWN OR SUSPECTED ACTIVE TB SHOULD BE REPORTED IMMEDIATELY BY PHONE!

Referring Agency/MD:				Phone:	
Address:				Fax:	
Client Name:			Date of Birth:	Age:	Sex: M F
Address, City, ZIP			County:	Phone:	
Country of Origin:			Month/Year Arrived in U.S.:		
Does this patient have medical coverage? Y N If yes, type:					
<i>Note: Non-HSA patients with medical coverage and an established medical home are not typically eligible for LTBI services through HSA.</i>					
TB Skin Test (TST)	Date Given	Date Read	Size ¹ (mm)	Facility Name Reading TST	
Current					
Prior ²					
Chest X-Ray	Date:	Results: (attach report)			
Facility/Provider Performing Chest X-Ray:					
Symptoms: (circle)					
Cough >3 weeks	Blood in Sputum	Night Sweats	Persistent Fever	Weight Loss	Fatigue Weakness
Call 454-4114 ASAP if you suspect active TB!					

Referrals for LTBI treatment should be made after the results of the patient's x-ray have been received. Please complete the Risk Assessment Scale.

¹ ≥ 5mm of induration is a positive TST result for all persons with the following conditions: known or suspected HIV infection, recent contact to an infectious case of laryngeal or pulmonary TB, chest x-ray that shows fibrotic changes consistent with TB, and chronic immunosuppression.

≥ 10mm of induration is a positive TST result for all persons except for those with the conditions outlined above.

² Prior **documented** TST only, not by patient history.