sonoma county
DEPARTMENT OF HEALTH SERVICES
Barbie Robinson, MPP, JD – Director
Karen Milman, MD, MPH – Health Officer

Please use this form to refer: **ACTIVE TB/SUSPECT TB or /CONTACTS TO CASES**

to download form: www.sonoma-county.org/tb

Patient Name: _____ DOB: _____

Mailing address: _____ City: _____ Zip: _____

Telephone: (Home) _____ (Work) _____ (Cell/Msg) _____

Language(s) **(mark all that apply)**: ENGLISH ❒ No ❒ Yes SPANISH ❒ No ❒ Yes OTHER ❒ _____

TB TEST RESULTS

1. Current Tuberculin Skin Test (TST/PPD) **Result—**Please indicate mm **size** of induration
Size recorded in mm: _____ mm. (induration) Date Placed: _____
Date Read: _____ Provider: _____

2. Previous TST (PPD) **Result—Mark one of the following boxes:**
❒ No prior TST (PPD)
❒ Prior documented TST _____ mm. (induration) Date Placed: _____ Date Read: _____ Where: _____
❒ Prior undocumented TST (per pt report) ❒ Pos ❒ Neg Date: _____ Where: _____
❒ Unknown

3. IGRA (TB blood test) **Result—Attach lab report.**
Date: _____ Result: ❒Negative ❒Positive ❒Indeterminate
❒ Quantiferon-TB Gold In-Tube _____IU/ml ❒ T-Spot.TB _____spot count #

4. Chest X-Ray—Attach current/prior reports if possible.
❒ Chest x-ray NOT ordered.
❒ Chest x-ray ordered. Date: _____ Facility Name: _____ Result: _____
- ❒ X-ray result pending.
- ❒ X-ray report attached.

5. Treatment—Has history of prior TB/LTBI diagnosis/treatment?
❒ No ❒ Yes **Attach medical records if possible**.

DOES PATIENT HAVE SYMPTOMS OF TB?

6. Symptoms

Cough	❒ No	❒ Yes	Onset Date _____
Fatigue	❒ No	❒ Yes	Onset Date _____
Fever	❒ No	❒ Yes	Onset Date _____
Anorexia	❒ No	❒ Yes	Onset Date _____
Night Sweats	❒ No	❒ Yes	Onset Date _____
Hemoptysis	❒ No	❒ Yes	Onset Date _____
Weight Loss	❒ No	❒ Yes	Onset Date _____

7. Risk Factors

Contact to TB Case	❒ No	❒ Yes	❒ Unk
Diabetic	❒ No	❒ Yes	❒ Unk
Foreign Born	❒ No	❒ Yes	❒ Unk
Recent Travel	❒ No	❒ Yes	❒ Unk
HIV +	❒ No	❒ Yes	❒ Unk
Homeless	❒ No	❒ Yes	❒ Unk
IVDU	❒ No	❒ Yes	❒ Unk
Recent Incarceration	❒ No	❒ Yes	❒ Unk

REFERRED BY: Contact Name: _____ Date: _____

Facility Name & Address: _____

Telephone: _____ Pager: _____ Fax: _____

Fax this referral form to Public Health Disease Control: (707) 565-4565

TB Clinic: 418 Riley Street, Santa Rosa, CA 95404

Print Reset Form

3/1/2016