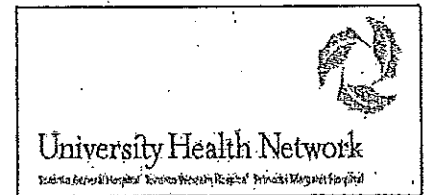


# TWH TB Clinic Referral Form



## Client Demographics

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Insurance:  OHIP  TB UP  
 IFH  Other  
Date of Birth \_\_\_\_\_ (mm/dd/yr)

Language Spoken: \_\_\_\_\_  
Interpreter Needed:  Yes  No

## Reason for Referral

- Known Active Disease       Contact of Active Case       Medical Surveillance  
 Rule Out Active TB       Positive TB Skin Test       Anti-TNF Treatment

## Diagnostic Tests (Please attach copy of all reports if possible)

TB Skin Test - Date: \_\_\_\_\_ (mm/dd/yr)      Result: \_\_\_\_\_ (mm) Induration

Chest X-ray - Date: \_\_\_\_\_ (mm/dd/yr)      Normal       Abnormal  \_\_\_\_\_

Microbiology - Date: \_\_\_\_\_ (mm/dd/yr)      Specimen Type: \_\_\_\_\_

Results: Smear \_\_\_\_\_      AMTD \_\_\_\_\_      Culture \_\_\_\_\_      Sensitivities \_\_\_\_\_

Pathology - Date: \_\_\_\_\_      Specimen Type: \_\_\_\_\_      Result: \_\_\_\_\_

## If Contact of an Active Case (Please provide INDEX CASE Information below (if available))

Smear \_\_\_\_\_      Culture \_\_\_\_\_      CXR Result \_\_\_\_\_

Sensitivities \_\_\_\_\_

Type of Contact: \_\_\_\_\_      Break in Contact \_\_\_\_\_ (mm/dd/yr)

## Comments

Referred by: Name: \_\_\_\_\_      Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

**PLEASE FAX REFERRAL TO TWH TB CLINIC - FAX (416) 603 - 5987**  
**TB CLINIC PHONE (416) 603 - 5853**