OUTPATIENT RULE-OUT TUBERCULOSIS REFERRAL FORM

1. Client's Name (Last, First MI):			2. Sex: ☐ Male ☐ Female
3. Date of Birth (mm/dd/yyyy):	4. Social Security Number:	5. Phone Number:	
6. Parent/Guardian (if minor):		7. P/G Phone Number:	

8. Client Home Address (Number & Street): City: State: ZIP:

9. Referred To:

Florida Department of Health-Bay County Tuberculosis Program
597 West 11th Street
Panama City, Florida 32401
850-872-4720, X1300
Medical Records Confidential Fax: 850-747-5475

10. Referring Provider/Agency:	11. Name of Person Making Referral:

12. Referring Office Mailing Address: City: State: ZIP:

13. Referring Office Phone Number:	14. Referring Office Fax Number:

15. 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 home until contacted by health department TB staff.

I understand this referral will result in all six of the following services being provided:

1. In-home evaluation.
2. At-home isolation.
3. QFT-Gold
4. Chest X-ray
5. Sputum for AFB x 3
6. Start four-drug therapy.

_____
Referring Physician's Signature Date

16. Response to Referral Originator:

Client Contacted By FDOHBC Staff On (date):_____

(check applicable)

_____ Evaluation determined no intervention needed.

_____LTBI therapy started.

_____Therapy for active TB initiated.

_____
FDOHBC TB Program Representative Signature Date

17.

Original mailed to doctor's office_____by_____
(date) (signature)