Ben Franklin TB Clinic and Case Management
Patient Referral

Please fax this form, along with any applicable progress notes, radiograph reports, and/or laboratory results to: (614) 645-8669

Patient Name: _____ Date of Birth: _____/_____/_____

Mailing Address: _____ City: _____ State_____ Zip: _____

Primary language: ☐ *English* ☐ *Nepali* ☐ *Somali* ☐ *Spanish* ☐ *Other:* _____

Phone: (Home) _____ (Work) _____ (Cell) _____

TB RISK

☐ Born in or traveled to country where TB is common? *If yes, what country?* _____ Year arrived in US_____

☐ Previously treated for active TB ☐ Contact to active TB ☐ HIV infection ☐ History of living in congregate setting ☐ Diabetes

☐ Treatment with TNF alpha inhibitor ☐ History of homelessness? I*f yes, currently housed?* ☐ *Yes* ☐ *No*

TB TESTING

☐ Documented tuberculin skin test: _____ *mm (induration)* ☐ *Negative* ☐ *Positive* Date: ____/____/_____

IGRA
☐ Quantiferon ☐ T-Spot TB ☐ *Negative* ☐ *Positive* ☐ *Indeterminate* ☐ *Borderline* Date: ____/____/_____

RADIOLOGY

Chest x-ray
☐ Not done ☐ Normal ☐ Abnormal Comment: _____ *Date:* _____/_____/_____ *Facility:* _____
CT scan
☐ Not done ☐ Normal ☐ Abnormal Comment: _____ *Date:* _____/_____/_____ *Facility:* _____

Other test name: _____
☐ Normal ☐ Abnormal Comment: _____ *Date:* _____/_____/_____ *Facility:* _____

LABORATORY TESTING

Sputum collect date: ____/____/_____
AFB Smear: ☐ *Negative* ☐ *Positive* *Culture*: ☐ *Negative* ☐ *Positive* ☐ *Pending* *PCR:* ☐ *Negative* ☐ *Positive*

BAL collect date: ____/____/_____
AFB Smear: ☐ *Negative* ☐ *Positive* *Culture*: ☐ *Negative* ☐ *Positive* ☐ *Pending* *PCR:* ☐ *Negative* ☐ *Positive*

Other specimen collect date: ____/____/_____
AFB Smear: ☐ *Negative* ☐ *Positive* *Culture*: ☐ *Negative* ☐ *Positive* ☐ *Pending* *PCR:* ☐ *Negative* ☐ *Positive*

SYMPTOMS

Cough: ☐ *No* ☐ *Yes* Anorexia: ☐ *No* ☐ *Yes* Fatigue: ☐ *No* ☐ *Yes* Night Sweats: ☐ *No* ☐ *Yes* Fever: ☐ *No* ☐ *Yes*

Hemoptysis: ☐ *No* ☐ *Yes* Weight Loss: ☐ *No* ☐ *Yes* *If yes, #*_____*lbs* Other symptoms: _____

REFERRED BY:

Provider name: _____ Facility/organization: _____

Office Address: _____ Phone: _____:

Fax: _____ Date: _____/_____/_____

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THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH