



# Outpatient Rule-Out Tuberculosis Referral Form

Please Type or Print Legibly

Client's Name (Last, First MI)		Date of Birth (mm/dd/yy)	Social Security Number	
Parent/Guardian Name (minors)				
Telephone Number	Home Address (no P.O. Boxes)	City	State	Zip
Referred To: <b>Bay County Health Department TB Program</b> Fax: 850-747-5475 Phone: 850-872-4720x1300				
Address: <b>597 W. 11<sup>th</sup> Street, Panama City, FL 32401</b>				
From (name of person making referral)		Fax Number:	Telephone Number:	
Office Name:				
Office Mailing Address:				

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 at home until contacted by health department TB staff.*

**I understand this referral will result in all six of the following services being performed:** 1) In-home evaluation 2) At-home isolation 3) TST 4) Chest X-ray 5) Sputum for AFB daily x 3 6) Start 4-drug therapy

\_\_\_\_\_  
 Referring Physician's Signature Date

Response to Referral Originator: Client contacted by BCHD staff on \_\_\_\_\_.  
(Date)

Evaluation determined no intervention needed  
 LTBI therapy started  
 Therapy for active TB initiated

\_\_\_\_\_  
 BCHD TB Program Representative's Signature Date

Original mailed to doctor's office \_\_\_\_\_ by \_\_\_\_\_.  
Date Signature