DALLAS COUNTY
HEALTH AND HUMAN SERVICES
Tuberculosis Elimination

Tuberculosis Infection Referral Form

Date: _________________

To: LTBI Referrals Fax Number: 214-819-5146 (secure) Phone Number: 214-819-2065	From: Referring Agency: __________________________ Contact Person:____________________________ Phone Number:_____________________________ Fax Number: ______________________________

Patient ____ Date of Birth: ____________

Address ____
Street City State Zip

Telephone Number: ____________________ Cell Phone Number: __________________

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Reason for Referral: Notification only_____ Evaluate for treatment _____

For appointments please call *214-819-2065 - Please inform us if you want your patient treated for LTBI.*

We will not contact your patient to schedule an appointment. Clients will not be seen without proper test results.

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TST result: _____mm Date placed: _______ Date read:________

IGRA result: ______ Date:_______ QFT or T Spot

Chest X-Ray result: ________________ Date:__________

Is patient on immunosuppressant medication? Y N
Is patient on dialysis? Y N

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Reply:

____
Signature and Title

____
Telephone Number

____
Date

2/20LG