LARIMER COUNTY | HEALTH AND ENVIRONMENT

1525 Blue Spruce Drive, Fort Collins, Colorado 80524, 970.498.6700, Larimer.gov

Tuberculosis Program Patient Referral

Reason for Referral (check all that apply):

☐ Patient has symptoms consistent with TB and/or is suspected of having active TB disease (e.g., abnormal chest x-ray)
☐ Patient has a positive TB skin test (TST) or TB blood test (Interferon-Gamma-Release Assay (IGRA)
☐ Patient has risk factors for TB

Referring Hospital, Clinic or Healthcare Provider

Name and Credentials: _____
Street Address: _____
City: _____ State: _____ Zip code: _____
Phone: _____ Fax: _____
Best person to contact for additional information (name, credentials, and contact information, if different from above):
_____

The following must be included with your referral:

☐ Positive TB skin test (TST) or TB blood test (IGRA) Interferon-Gamma-Release Assay results
☐ Chest x-ray report
☐ Relevant clinical notes
☐ Lab results (include HIV, CBC, CMP, other)

Please complete this referral form in entirety, including the Surveillance and Case Management Report Tool (TB-18) attached. Incomplete information may result in delays in responding to the referral.

Contact the Larimer County Department of Health and Environment (LCDHE) TB Program with any questions by phone: 970-498-6708, email: comm-disease@co.larimer.co.us, or fax: 970-498-6772. Healthcare providers who suspect active TB disease in a patient should immediately report via phone at 970-498-6708 or after-hours at 970-416-1985.

LARIMER COUNTY

TUBERCULOSIS SURVEILLANCE AND CASE MANAGEMENT REPORT TB-18

COLORADO
Department of Public Health & Environment

4300 Cherry Creek Drive South
DCEED-TB-A3
Denver, Colorado 80246-1530
(303) 692-2638 Phone (303) 759-5538 Fax

TBdb# _____

DEMOGRAPHICS

Last Name _____ First Name _____ MI _____

Date of Birth ___/___/___

Gender ☐ Male ☐ Female

Race ☐ American Indian/ Alaska Native ☐ Asian ☐ African-American/ Black ☐ Native Hawaiian/ Pacific Islander ☐ White ☐ Unknown

Ethnicity ☐ Not Hispanic/Latino ☐ Hispanic/Latino

Country of Birth ☐ United States ☐ Mexico _____ Specify other

Date Arrived in US ___/___ Month/Year

Date Arrived in CO ___/___ Month/Year

Country of Birth of Parents/Guardians _____ (Under 18 y/o)

Occupation
☐ Health care worker
☐ Corrections employee
☐ Migrant/seasonal worker
☐ Unemployed past 12 months
☐ Not seeking employment
☐ Retired
☐ Unknown
☐ Other _____ Specify other

Employer _____

LOCATING and ADDITIONAL INFORMATION

Current Home Address _____ Apt # _____

City _____ State _____ Zip Code _____ County _____

Other Address _____ Specify Type _____

City _____ State _____ Zip Code _____ County _____

( ) _____ Home Phone ( ) _____ Other Phone _____ Specify Type

( ) _____ Work Phone Email _____

Preferred Language _____

Interpreter Needed ☐ Yes ☐ No

Insurance _____ (Medicaid, Medicare, private (name), none)

Date Patient Reported to LPHA ___/___/___

REASON FOR EVALUATION

☐ Administrative
☐ Class B TB notification
☐ Incidental lab result
☐ Employment
☐ Immigration medical exam
☐ Abnormal CXR
☐ Known active
☐ Health care worker
☐ Suspect case
☐ Symptomatic
☐ Targeted testing- individual
☐ Targeted testing- pregnancy
☐ Targeted testing- specific project
☐ Transfer case/suspect
☐ Contact investigation*
☐ Source case investigation*
* Index case TBdb# _____

TST AND IGRA

Current TST Date Placed ___/___/___ Date Read ___/___/___ Induration _____ mm

Previous TST Date ___/___/___ Induration _____ mm

☐ TST conversion in last 2 years

IGRAs ATTACH ALL LAB RESULTS TO THIS DOCUMENT

Collection Date ___/___/___ Testing Laboratory _____

IGRA Results ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown

Type of IGRA ☐ Quantiferon (Qiagen) ☐ T-Spot (Oxford Immunotec) ☐ Other _____ (If other, list test type)

IMAGING

Imaging ATTACH ALL IMAGING RESULTS TO THIS DOCUMENT

☐ X-Ray
☐ CT
☐ MRI

Date Taken ___/___/___ Name of Facility _____

Previous Imaging
☐ Yes
☐ No
☐ Unknown

Name of Facility _____ Date Taken ___/___/___

Last Name _____ First Name _____ DOB ___/___/___

MEDICAL HISTORY

Symptoms **Symptom Length**

- ☐ None
- ☐ Cough _____
- ☐ Hemoptysis _____
- ☐ Chest pain _____
- ☐ Weight loss _____
- ☐ Night sweats _____
- ☐ Urinary _____
- ☐ Fever _____
- ☐ Other (specify) _____

Medical History

- ☐ None

GI

- ☐ Gastrectomy
- ☐ Jejunoileal bypass
- ☐ GU problems
- ☐ Weight loss > 10 lbs
- ☐ GI issues

Immunosuppression

- ☐ Diabetes mellitus
- ☐ Renal failure
- ☐ HIV
- ☐ Immunosuppressive therapy

Chest

- ☐ Chest injury
- ☐ Heart disease

Lung

- ☐ Silicosis
- ☐ Lung disease _____ (specify type)

Liver

- ☐ Hepatitis
- ☐ Liver disease

- ☐ **Transfusion**
- ☐ **Surgeries** _____
- ☐ **Cancer** _____
- ☐ **Other** _____

Special Conditions

- ☐ Pregnant EDD ___/___/___
- ☐ Postpartum breast feeding

Weight _____ **Height** _____

Previous TB Diagnosis

- ☐ Yes
  - ☐ TB Infection
  - ☐ TB disease

  Completed Treatment for TBI or TBD
  - ☐ Documented
  - ☐ Verbal
- ☐ No
- ☐ Unknown

BCG Vaccine ☐ Yes ☐ No

___/___/___
Vaccine date

Drug Allergies _____

Medications ☐ Yes* ☐ No

***List recent/current meds and/or previous TB meds below including birth control**

Medication	Dose	Purpose	Start Date

Smoker

- ☐ Yes
  - ☐ Current
  - ☐ Past
  - ☐ Date quit ___/___/___

  Packs per day _____
- ☐ No

Exposure Risks

- ☐ None
- ☐ Homeless
- ☐ Refugee camp
- ☐ Patient lived/traveled outside of US for >1 month List countries _____
- ☐ Resident of correctional facility _____ Facility name, type, & location
- ☐ Resident of long term care facility _____ Facility name, type, & location

HIV Test **HIV Test Date**

- ☐ Postive
- ☐ Negative ___/___/___ Date in last year
- ☐ Not done
- ☐ Unknown

Alcohol Use

- ☐ Yes _____ Drinks per week
- ☐ No
- ☐ Unknown

Drug Use

- ☐ Injecting
- ☐ Noninjecting
- ☐ No
- ☐ Unknown

PROVIDER INFORMATION

Local Health Agency (LHA) _____ PCP/Clinic Name _____ (___) PCP Phone Number

(___) PHN Direct Line (___) LHA Fax Number _____ PCP/Clinic Address (___) PCP Fax Number

Nurse Case Manager _____ PCP City _____ PCP State _____ PCP Zip Code

SIGNATURE

Person Completing Form (Signature) _____ **Person Completing Form (Print)** _____ ___/___/___ Date Interview Completed

Additional Comments or Notes

*Updated 6/2017