SCHENECTADY COUNTY PUBLIC HEALTH SERVICES
107 Nott Terrace Suite 100
Schenectady, NY 12308
Phone-518-386-2824 FAX- 518-386-2278

Latent TB Infection (LTBI) Referral Form

IMPORTANT NOTICE:
This form is for **non-urgent referrals** only. If **active TB** is suspected or there are special concerns, please call the TB clinic at **386-2824 ext. 1272** when making a referral.
Please **fax** the completed report to **518-386-2278.** Form to be completed in its entirety by **medical personnel** or the **referring agency**.

Demographic Information

Name:(last, first) _____ Phone: _____
DOB: _____ **Home Address:** _____
Preferred Pronouns: _____ _____
Sex: _____ **Race:** _____ **Ethnicity:** _____
Country of Birth: _____ **Date of Entry to U.S.** _____
Primary Language: _____ **Interpreter Needed:** _____

Insurance Carrier: _____ **Insurance ID:** _____

Diagnostic Information

Current PPD/TST:(Placed: mm/dd/yyyy) _____ (Read: mm/dd/yyyy) _____ Result: (mm) ____ ☐Positive ☐Negative
Previous PPD/TST:(Placed: mm/dd/yyyy) _____ (Read: mm/dd/yyyy) _____ Result: (mm) ____ ☐Positive ☐Negative

IGRA ***QuantiFERON/T-Spot Date:** _____ **Results:** ☐Positive ☐Negative ☐ Indeterminate/Borderline
*Please Attach Results

CXR: **Date:** _____ **Location:** _____ **Results:** ☐Normal ☐Abnormal *Please Attach Results

Medical History/Risk

History of prior BCG: ☐Yes ☐No **History of previous Tx for TB/LTBI?** ☐Yes, Year: _____ ☐No

Signs/Symptoms of TB: ☐None ☐Unexplained weight loss ☐Cough lasting **3 weeks or more** ☐Hemoptysis
☐Chest pain ☐Loss of appetite ☐Night sweats ☐Unusual fatigue ☐Chills/Fever (unknown origin) ☐Other:

Risk Factors:
☐Exposure to active TB ☐Foreign born ☐Immunosuppressive medication ☐IVDU ☐Fibrotic changes on CXR
☐Resident/employee in high-risk setting (NH, correctional facility, hospital, homeless shelter) ☐Frequent or extended travel outside U.S
☐Medical condition associated w/ increased risk of developing TB if infected (e.g., cancer, diabetes, silicosis) ☐Other:

Specialist Referrals:

Has the patient been referred to any specialists (e.g., infectious disease, pulmonary, etc.): ☐Yes ☐No
If yes, Provider Name: _____ Specialty: _____
Additional Notes: _____

Referral Source/Contact Information:

Referring Agency/Provider: _____ Phone Number: _____
Contact at Referring Agency: _____ Fax: _____
Patient's PCP: _____