CLINTON OFFICE
1307 E. Townsend Rd.
Saint Johns, MI 48879-9036
(989) 224-2195

GRATIOT OFFICE
151 Commerce Dr.
Ithaca, MI 48847-1627
(989) 875-3681

MONTCALM OFFICE
615 N. State St.
Stanton, MI 48888-9702
(989) 831-5237

LTBI Treatment Referral

Referred by:____ Phone:__________________ Date of Referral:_____________

Demographics

First Name:___________________________ Last Name:_________________________ (M.I.): _____ Sex: ☐ Male ☐ Female

Date of Birth:____________________ If Patient <18 years, Name of Parent: ____________________________________

Address:____ Phone: ____________________________

City: _____________________________ State: _____ Zip:_______________ County: ___________________________

Primary Care Physician: ____ Phone: __________________________

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Pacific Islander ☐ American Indian or Alaska Native

Ethnicity: ☐ Non-Hispanic ☐ Hispanic Primary Language:___________________ Need Interpreter? ☐ Yes ☐ No

Patient Weight: _____________ Does patient have health insurance? ☐ No ☐ Yes If yes, name: ______________________

Health Information

Reason for Testing: ☐ Contact to Active TB Case ☐ Foreign Born; Country of Origin _______________________________

☐ Substance Abuse ☐ Immunocompromised ☐ Lives in Congregate Setting ☐ Diabetic ☐ Immigration ☐ Occupational

☐ Other: ____ BCG Given Date: _______________

Screening Test: ☐ TST_____ mm Date Placed: _________________ Date Read: _________________

☐ QuantiFERON Result: ☐ Pos ☐ Neg ☐ Indeterminate Date of Test Collection: ___________________

☐ T-Spot Result: ☐ Pos ☐ Neg ☐ Indeterminate Date of Test Collection: ___________________

Date of Test Collection: ___________________ AST _____ ☐ Normal ☐ Abnormal ALT _____ ☐ Normal ☐ Abnormal

Chest X-Ray: Date: _____________ ☐ Normal ☐ Abnormal, Results: ____________________ ☐ Copy Faxed with Referral

Previous X-ray/Screening Tests Dates & Results: ____

Clinician has ruled out active TB disease?: ☐ Yes (i.e., no TB-related symptoms or physical findings)

☐ No Symptoms ☐ Symptoms: ☐ Productive, Prolonged Cough ☐ Chest Pain ☐ Blood in Sputum ☐ Weight Loss

☐ Appetite Loss ☐ Fatigue ☐ Night Sweats ☐ Fever ☐ Chills ☐ Swollen Glands ☐ Shortness of Breath

☐ Other Symptoms: ____

☐ No Significant Medical History Reported ☐ Medical History (Check all that apply): ☐ Diabetes ☐ Hepatitis ☐ Smoker

☐ Cancer, Type: _______________☐ Lung Disease ☐ Immunosuppressive ☐ On Birth Control, Method: _______________

☐ Pregnant, Due Date: _____________ Other Health History: ____

Medications: ____

☐ NKDA ☐ Drug Allergies: ____

HIV Test Date: _________________ ☐ Positive ☐ Negative ☐ Unknown ☐ Not Done

Fax Referral to Clinton County 989-227-3126, Gratiot County 989-875-1032, or Montcalm County 989-831-3666