BC Centre for Disease Control
Provincial Health Services Authority

Tuberculosis Clinic Referral Form

Vancouver Tel: 604-707-2692 **Fax: 604-707-2690**	**New Westminster** Tel: 604-707-2698 **Fax: 604-707-2694**
REFERRING PROVIDER	
Name/MSP#	**Referral Date** YYYY/MM/DD
Phone	**Fax**
☐ **MEDICALLY URGENT, call 604-707-2720 in addition to faxing referral**	☐ **Non-Urgent Referral**
CLIENT DEMOGRAPHICS	
Name on BC Services Card LAST FIRST MIDDLE	
Personal Health Number	**Date of Birth** YYYY/MM/DD
Phone Number(s)	**Current Address**
Designated spokesperson (if applicable)	**Translator Required** No ☐ Yes ☐ If yes, Language:
CLINICAL INFORMATION (Required for triage)	
Country of Birth	
Prior TB Treatment No ☐ Yes ☐	**TB Exposure** No ☐ Yes ☐
TB Skin Test No ☐ Yes ☐ If yes, date: Result: _____(mm) If yes, reason for TB Skin Test:	**IGRA** No ☐ Yes ☐ If yes, date: Result: ☐ Non-Reactive ☐ Reactive If yes, reason for IGRA:
TB Signs and Symptoms:	
Medical History/Medications (Attach relevant consultations, labs, and imaging reports)	
REASON FOR REFERRAL (Required)	
☐ **TB Clinician Consultation** Please indicate reason below (Required)	
☐ AFB smear positive or PCR positive or MTB culture positive	☐ Symptoms suggestive of TB (Collect 3 sputa for AFB smear and culture. CXR required)
☐ CXR/CT scan suggestive of TB (Attach recent CXR or imaging reports)	☐ Other: (Attach relevant clinical information)
☐ **TB Screening and/or Nursing Assessment** Please indicate reason below (Required)	
☐ Cancer ☐ Immune Suppression: ☐ Pre-Biologic **Estimated start date:**	☐ Other:
☐ Ophthalmology (attach relevant consult notes): _____	☐ **Concern for active ocular TB (Call 604-707-2720)**
Test requested ☐ TST ☐ IGRA Consult	
*If screening request due to pre-biologics or immune suppression, attach a CXR within the past six months. Refer to the BCCDC TB Manual, Section 4(b), Table 8-Clients with Medical Risks Factors.	