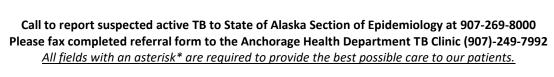
Anchorage Health Department Tuberculosis (TB) Clinic Referral Form





Reason	for Referral	_		ate for Latent TB Infection	
Referring Provider, Clinic or Hospital?					
*Name*Contact Person					
*Addres	*Address *City		City	*Zip Code	
*Phone		Fax		Email	
Preferred contact method?*Would you like to be notified of the outcome of this referral? Yes \(\text{No} \)					
Patient Information *Patient Name: *Last		*First	*Date of Birth		*Gender
*Addres	ss	Apt#	City	State	Zip Code
*Best number to contact patient Last 4 digits of Social Security Number					
Country of birth		*Language	*Language		oreter needed? Yes No
*IGRA Results: *Please Check One			*CXR reading: (Please attach reading)		
	☐ QuantiFERON ☐ T-Spot	or Not done		□ Normal □ Al	bnormal
	Date: Result			*Patient must bring act	ual CXR film/CD or any other
*TB Test Results:			imaging done in the last three (3) monthhs to TB		
Date Place: Date Read:		Size:	(mm)	appointment	
	☐ Positive ☐ Negative	☐ Not Done			
If the patient is showing any symptoms of TB such as cough, fever, night sweats, weight loss or fatigue,					
please call (907) 727-7536 to speak to the TB Nurse.					
Screening Questions:					
1. Symptoms? (please describe)					
2.	Has the patient been given any medications for this condition? No Yes (if Yes, please explain)				
3.	TB risk factors?				
4.	Any other health conditions or concerns?				
5.	Any lab work? (AFB on any fluids/tissue, liver functions test, CBC w/diff.)(Please attach)				
6.	Medications currently taking (Please attach list)				
7.	HIV status? ☐ Positive ☐ N	egative 🔲 Unkr	nown		