Bethlehem Health Bureau
Tuberculosis Investigation/Referral Form

Phone: 610-865-7087 Fax to: 610-865-7326

(City of Bethlehem residents only)

Print

Name: _____ Date: _____
Address: _____ Bethlehem, PA 180 ___
Phone No: _____ DOB _____ Age _____
E-mail _____ SSN: _____
Country of birth: _____ Race/Ethnicity _____
If applicable, Date of entry into USA and Visa type: _____
Does this person speak English? Yes No (specify language _____)
Does this person have health insurance? Yes No

PPD
Date applied: _____ Date read: _____ Result _____ mm
Reason for PPD: ____ work ___ school ____ TB contact ___ other – give reason _____
Previous PPD: _____ mm Date: _____

CXR
Date: _____ Place: _____ CXR results: _____ (please attach report)

IGRA (Quantiferon TB Gold or T-Spot – circle one)
Date _____ Result: _____ Positive ____ Negative ____ Indeterminate
Previous? Date _____ Result: _____ Positive ____ Negative ____ Indeterminate
Reason for IGRA _____

Past Medical History :
Illness _____
Medications _____
BCG vaccine: _____ YES, age: _____ ____ NO ____ Unknown

S/S of TB:
___ none ____ cough ____ night sweats ___ weight loss ___ fever ___ fatigue
____ other: Explain _____

Exposure:
TB disease: _____ Yes _____ No _____ Unknown
Who _____ Where _____ Date _____

Referral Info:
Information Source _____ Phone _____
Make TB clinic appointment? □ YES □ NO If NO, start date of INH treatment _____

PLEASE MAKE SURE TO INCLUDE A COPY OF ALL LAB AND RADIOLOGY REPORTS WITH REFERRAL TO THE BETHLEHEM HEALTH BUREAU

2013/AA