



**Hasbro Children's TB Clinic Referral: Please call for an appointment BEFORE faxing this referral.
Wednesday and Thursdays 444-3851**

Hasbro Children's Hospital TB Clinic 593 Eddy Street Hasbro Lower Level Providence, RI 02903 (401)444-3851 (401) 444-3870(fax)	Date of appt.: _____ Time: _____
	Referring provider: _____
	Address: _____
	Phone: _____
	Fax: _____

Demographics

Last name	Insurance information
First name	
Address	Coverage
	Policy #
	PCP name
Street	PCP telephone
City	Primary language:
State	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:
Zip	
Phone 1:	DOB
Phone 2:	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

Clinical Information

<u>PPD skin tests</u> (list all available results) PPD(1) Date planted: _____ Date read: _____ Results: _____ mm induration	Appointments are prioritized based on <u>TB risk factors</u>. Completion of this section enables prioritization: <input type="checkbox"/> Diabetes <input type="checkbox"/> Chronic renal failure <input type="checkbox"/> Cancer (on treatment) <input type="checkbox"/> Immunosuppressive disease <input type="checkbox"/> Steroid therapy (>20mg/day prednisone for >30 days) <input type="checkbox"/> Taking or candidate for TNF-inhibitor <input type="checkbox"/> Active substance abuse <input type="checkbox"/> Documented PPD converter within last 2 years <input type="checkbox"/> Other: <input type="checkbox"/> None of the above
PPD(2) Date planted: _____ Date read: _____ Results: _____ mm induration	
History of BCG? (circle one) Yes No	
<u>Does patient have a history of hepatitis?</u> <input type="checkbox"/> No <input type="checkbox"/> Yes: Please fax all available hepatitis and LFT results.	
<u>Chest X-ray</u> <input type="checkbox"/> Not done <input type="checkbox"/> Done, report included (Fax to RISE with referral) <input type="checkbox"/> Done, report not included CXR date: _____ CXR location: _____	Pregnant: <input type="checkbox"/> No <input type="checkbox"/> Yes, due date: _____
<u>Referring provider must speak with Hasbro provider if CXR is abnormal and patient is suspected of having active TB.</u>	HIV: <input type="checkbox"/> Not done <input type="checkbox"/> Done, report included (Fax to Hasbro with referral)
	<u>Referring Provider Comments:</u>

Hasbro Provider Feedback: