PEDIATRIC TUBERCULOSIS REFERRAL

Contact booking desk at **905-521-2100 x 73861** for any further questions

Please fax completed forms to:

905-521-2654

Date of Referral: _____

Patient Information

Name: _____

DOB: _____ _____Male _____Female

Health Card # _____ (OHIP)

Address: _____

City: _____ Postal Code: _____

Telephone: _____ Cellular: _____
Interpreter required:_____
CAS/FACS involvement: _____
Family Physician: _____

Referring Physician Information

Name: _____

Address: _____

Postal Code: _____

Telephone: _____

Fax: _____

Physician Billing #: _____

Signature: _____

REASON(S) FOR CONSULTATION (*Please select all that apply)*

□ Asymptomatic Household TB contact
□ Symptomatic Household TB contact
□ Positive TB skin test (asymptomatic)
□ Abnormal CXR

□ Other:
_____
_____

Details of Referral *(frequency of symptoms, other signs and symptoms):*

_____
_____
_____

Medications: _____

Please attach ALL supporting information *(Please select all that apply):*

□ Last clinical letter □ Tuberculin skin test results □ Sputum culture
□ Vaccine record □ CXR results □ IGRA results
□ Other: _____

Pediatric Infectious Diseases Office Use Only

ID physician Notes: _____
_____
_____
_____

□ Blood work _____ □: CXR _____
□ CT _____ □: Tst _____
□ IGRA_____
□ Visit: _____
□ MFPID

Triage Dr: □ PERNICA □ WONG