



Queensland Government

Metro South Clinical Tuberculosis Service

Tuberculosis Screening Referral

(Affix identification label here or complete if E-Form)

URN: NO STICKER REQUIRED

Family name:

Given name(s):

Address:

Date of birth: Sex: [] M [] F

To: MSCTBS, Building 37, PA Hospital, 199 Ipswich Road, Woolloongabba Qld 4102 Fax referral to : 3176-4192

From Clinic Name: Address: Phone: Fax: GP Details: Email (not for clinical information):

Generate form after live vaccines have been administered.

Date last MMR, Varicella or Zostavax given/..../.....

Family Contact

Patient Details Family Name: Given Names: Date of Birth: Sex: [] Male [] Female Address: Phone number: Mobile: Country of Origin: Language: Interpreter Required: [] Yes [] No Medicare No. No. on Card: Expiry:

Reason for Referral [] TB contact [] Refugee screening [] Update patient records* *Reason for update: [] moved interstate [] new GP [] changed address [] changed phone no.

Clinical Details BCG Scar: [] Yes [] No Date of CXR (If done): Where x-ray was performed:

Progress Notes

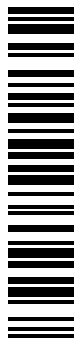
Case Manager Name: Phone: Organisation: Email:

Pathology Laboratory [] Mater [] QML [] S&N [] Q Health (Pathology Qld)

MSCTBS use only MANTOUX READ RESULT.....mm. Result sent to: Date:/..../.....

DO NOT WRITE IN THIS BINDING MARGIN

V4.1 02/2017 Locally Printed



MSH059

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