MSH059

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

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Locally Printed

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