REFERRAL TO ALLEGHENY COUNTY HEALTH DEPARTMENT PULMONARY CENTER

Name of Person Referring	***SEND TO:*** **Pulmonary Center** **425 First Avenue, 1st Floor** **Pittsburgh, PA 15219** **Phone: (412) 578-8162** **FAX #: (412) 578-7905**
Name of Agency	
Address	
Phone: **Date:**	
Name of Person Referred Last First	**Date of Birth** / **Sex**
Street Address	**Last 4 digits of Social Security #:**
City-Boro-Town **State** **Zip Code**	**Occupation**
Country of Origin **Date of Entry to U.S.**	**Phone - Home** **Office**

REASON FOR REFERRAL:

1. Tuberculin skin test: [ ] Mantoux [ ] Tine *(no longer recommended)* [ ] Q-Gold_____

Testing Facility: _____

Site (forearm): L__R__ Date Given:_____ Date read _____ Induration:____ MM Read by: _____
(measure only across forearm) *name*

2. BCG Vaccination ____Yes _____No Date(s)_____ Where_____

3. Recent Converter *A person whose tuberculin reaction increases ≥10 mm within a 2 year period of a prior test.*

Non significant (negative) test: Date(s)_____MM of induration _____

Significant (positive) test: Date(s)_____MM of induration_____

4. Known Exposure to infectious TB: _____

5. Risk of exposure to infectious TB: Close Contact to:_____

High Risk Environment (specify): _____

6. Symptomatic (prolonged cough (>3wks), blood-streaked sputum, chest pain, weight loss, fatigue, fever, night sweats, swollen glands):

_____

7. Last Chest X-ray: Date _____ Location_____

Official Reading:_____

PLEASE HAVE PATIENT BRING ACTUAL FILM OR DISC WHEN THEY COME TO OUR PULMONARY CENTER.

8. Medical History: Allergies, Seizures, Liver disease, Diabetes, Pneumoconiosis, Hodgkins disease, Cancer on therapy, Gastrectomy or iliojejunal enterostomy, on immunosuppressive drugs, radiation therapy, steroid therapy, etc. Please indicate:_____

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