Albany County Department of Health
TB Control Program Referral Form
Phone: (518) 447-4640
Fax: (518) 447-4515

Please complete ENTIRE form. Send via fax along with CXR report and relevant lab results (CMP, CBC, IGRA)

Referring information: Date: _____
Referring agency: _____ Phone #: _____
Name of medical staff filling out form: _____

Patient information:
Name: _____
Last First
DOB: _____ Age: _____ Sex: _____ Race: _____

Address: _____ Phone # (H): _____
_____ Phone # (C): _____

Interpreter needed: **YES or NO** Birth Country: _____
Language: _____ U.S. Entry Date: _____

Does patient have a PCP? **YES or NO**
Primary MD: _____

Does patient have medical insurance? **YES or NO**
Insurance carrier: _____ Insurance ID#: _____

Medical History:
Has patient had BCG vaccination? **YES or NO** Allergies: _____
Signs/symptoms of TB: **YES or NO** Current Medications: _____
If yes, explain: _____ _____
Any KNOWN exposure to pulmonary TB: **YES or NO** _____
If yes, explain: _____ _____
Any TRAVEL outside of U.S. and home country? **YES or NO**
If yes, explain: _____

IGRA QFG/TSpot (if done): Date: _____ Result: _____

Previous PPD (if known):
Date given: _____
Where given: _____
Induration in mm: _____

Current PPD (if done):
Date given: _____
Where given: _____
Induration in mm: _____

Chest x-ray: Where done: _____ Date: _____

ACHD Staff Only:
Date and Time of ACHD Appointment
___/___/___ _____ am/pm

ALBANY COUNTY Cares about our health

Revised: 9/21/16, 9/27/19