Tuberculosis Care Center
of Central & Northern Michigan
Referral Form

Please complete as much information as you are able.

If TB disease is suspected or has been confirmed, please report this immediately to the Tuberculosis Care Center (TBCC) of Central & Northern Michigan at phone: 877-271-1362 or tbcc@cmdhd.org. You can also complete the following referral form.

Please complete and email (tbcc@cmdhd.org) or fax (866-511-5756) the following form with a current medication list, any relevant radiology reports, lab records, and narrative notes that have not been contributed to MiHIN.

Date:

Referring Provider Information

Name:

Street Address:

City: State: Zip:

Phone: Fax:

PCP Name (if different):

Patient Information

Name: First: Last: MI:

If Minor: Parent/
Guardian Name: First: Last:

Street Address:

City: County: State: Zip:

Preferred phone: Other phone:

Preferred contact method: Call ☐ Text ☐ Email:

Gender at Birth: Male ☐ Female ☐ Date of Birth:

Country of Birth: Date Arrived in US:

Interpreter Needed? Yes ☐ No ☐ If interpreter needed, what language?

Medical Information

Symptoms: If more than one symptom box is checked, call the TBCC at 1-877-271-1362 before sending the referral.

☐ None ☐ Cough ☐ Weight loss ☐ Fatigue Other:
☐ Fever ☐ Night sweats ☐ Hemoptysis ☐ Loss of appetite

Medical Conditions (*check all that apply and send applicable medical records if not in MiHIN system*)

On or plan to start immunosuppressing drug? Yes ☐ No ☐ If Yes, list drug:

☐ HIV Date of most recent HIV test: ☐ Immunosuppressive condition ☐ Diabetes mellites

☐ Organ Transplant ☐ Chronic renal failure requiring dialysis ☐ Liver disease/abnormal LFTs

☐ Cancer If yes, cancer type: ☐ Currently on chemotherapy

☐ History of GI bypass/bariatric surgery ☐ Gastrectomy ☐ Vitamin D deficiency

☐ Silicosis Pregnant? Yes ☐ No ☐ If Yes, EDC

History of TB or LTBI treatment in past Yes ☐ No ☐ If yes, explain:

TST: #1 Date read: Size: mm #2 Date read: Size: mm

IGRA (QFT/TSPOT)#1Date: Results: #2Date Results:

Chest x-ray Date: Incomplete/pending ☐ Normal ☐ Abnormal ☐

Chest CT Date: Incomplete/pending ☐ Normal ☐ Abnormal ☐

Sputum Date: Results:

Notes/Additional Information:

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