TRANSPLANT LTBI REFERRAL

BC Centre for Disease Control
Provincial Health Services Authority

Vancouver Tel # 604-707-2692
Fax # 604-707-2690

New Westminster Tel # 604-707-2698
Fax # 604-707-2694

REFERRAL TO

☐ **Vancouver TB Clinic,** 655 W12th Avenue ☐ **New Westminster TB Clinic,** 100-237 E Columbia St

REFERRAL FROM

Referring Provider's Name: _____ Date (yyyy/mm/dd):_____

Phone: _____ Fax: _____

CLIENT DEMOGRAPHICS

Name: (Last) _____(First) _____ (Middle)_____

DOB (yyyy/mm/dd):_____ Gender: _____

PHN: _____ Primary Tel#: _____

Address:_____

Client MRP: _____ MRP Phone number: _____

Current location of client: ☐ Hospital ☐ Home (see address above)

Interpreter Services Required: ☐No ☐Yes: Language: _____

Please fax the following to BCCDC TB Services (TBS) along with this completed referral*:

☐ IGRA/TST result ☐ CXR or imaging (most recent) ☐ Consult Note(s)

*Please note: Incomplete referrals will be returned to referring physician

REASON FOR LTBI REFERRAL BY TRANSPLANT TYPE

☐ **BMT**	☐ **SOT**
☐ LTBI on treatment Start date: _____ Treatment: _____	☐ Pre or post-transplant on LTBI treatment Start date: _____ Treatment: _____
☐ Post-transplant for LTBI treatment initiation ☐ IGRA reactive ☐ TST positive	☐ Living donor for LTBI treatment ☐ IGRA reactive ☐ TST positive
☐ Imaging abnormal; high incidence country, for consideration of LTBI treatment	☐ Post-transplant for LTBI treatment initiation ☐ Donor with LTBI ☐ Recipient with LTBI
☐ Other, please specify:	☐ Post-transplant, for screening +/- LTBI treatment
	☐ Pre-transplant, for screening +/- LTBI treatment

Office use only: Date received: _____ Client ID#: _____

Reports entered: ☐ yes ☐ no Previous TB record: ☐ no ☐ yes Print 939 report