ACHD Staff Only
Reviewed By_____
Date_____

Albany County Department of Health
TB Control Program Intake Form
Date and Time of ACHD Appointment __/__/__ _____pm
Phone (518) 447-4640

Form to be completed **in its entirety, <u>including chest x-ray report and labs attached,</u>** by medical personnel/referring agency. **<u>Fax</u>** completed form to ACDOH at **<u>(518) 447-4515.</u>**

Name: _____
Last First

DOB: _____ Age: _____

Address: _____ Phone # (H): _____

_____ Phone # (W): _____
Phone # (C): _____

Sex: _____ Race: _____ Birth Country: _____ Entry Date to U.S.: _____

Primary language: _____ Interpreter needed: _____

Referring agency: _____ Phone: _____

Primary MD: _____ Phone: _____

Address: _____

***Insurance carrier: _____ Insurance ID#: _____**
** (Please indicate if patient has no insurance. Insurance information is required to process referral.) **

Medical History
Hx of prior BCG: Yes No Year: _____
Medications: _____ Allergies: _____

_____ _____

S/S of TB: _____

Known Exposure to pulmonary TB: _____

TRAVEL outside of U.S. (for > than 1 month): where and for how long?

_____

IGRA: Q-Gold/T-Spot Test Date: _____ Result: _____

Previous PPD:
Date given: _____
Where: _____
Induration in mm: _____
Manufacture Lot#: _____
Exp: _____

Current PPD:
Date given: _____
Where: _____
Induration in mm: _____
Manufacture Lot#: _____
Exp: _____

Chest x-ray: Where done: _____ Date: _____
Please instruct patient to bring X-ray and any medication to appointment.

Signature/Title: _____ Date: _____