Excellent care, for everyone,
everywhere, every time.

island health

REFERRAL to Island TB Program
Please fax to 250-519-1505

* A chest x-ray within 6-months of referral is required *

Referring physician: ______________________________

Physician Address: ______________________________

Phone #: ______________________ **Fax #:** ______________________

Patient name: ______________________ **PHN:** ______________________

DOB: ______________________ **Tel#:** ______________________

Address: ______________________________

Family Practitioner: ______________________________

Reason for TB Referral:

- ☐ **Pre-biologics**
- ☐ **Symptoms:** (Please specify)______________________________
- ☐ **Previous positive tuberculin skin test/ past treatment for TB**
- ☐ **Other** (please specify):______________________________

Patient Medication List:

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