REFERRAL to Island TB Program

Please fax to your local Public Health Unit:

https://www.islandhealth.ca/our-locations/health-unit-locations

* 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:

_____

_____

Island TB Program
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