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island health

# REFERRAL to Island TB Program

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

**Referring physician:** _____

**Patient name:** _____ **DOB:** _____

**PHN:** _____ **Tel#:** _____

**Address:** _____

## TB screening is required for:

- ☐ **Pre-biologics/ immunosuppressant treatment:**
  Please specify current Immunosuppressant medications/dose
  _____
  _____
- ☐ **Symptoms:**
  (Please specify)_____
- ☐ **Previous positive tuberculin skin test/ past treatment for TB (CXR required).**
- ☐ **Ophthalmology.**
- ☐ **Other** (please specify):_____

Please note that some results may take up to 5-weeks.

## Please fax referral to Island TB Program at 250-519-1505.

**Island TB Program**
*Royal Jubilee Hospital, Royal Block 4.*
*1952 Bay Street.*
*Victoria, BC V8R 1J8*
Tel: 250-519-1510 | Fax: 250-519-1505