National TB Centre, St. James's Hospital

Referral Form

Personal Details

Patient Name			
Patient Age		Date of Birth	
Interptreter Required	Yes / No	Language	
Patient Address			
Eircode			
Mobile		Landline	
Email			

Referrer Details

Consultant			
Address			
Mobile		Landline	
Email			

Have you informed the patient that you suspect Tuberculosis?	Yes / No
Have you told the patient they will be offered an appointment?	Yes / No
Has the patient had a previous diagnosis of Tuberculosis	Yes / No

GP Details			
Address			
Eircode			
Mobile		Landline	
Email			

Symptoms & Clinical Findings

Presenting Complaints/Symptoms:

Relevant Medical History:

Radiology Performed

Chest XR	Yes / No	Date of Scan	
CT Thorax	Yes / No	Date of Scan	
Is Radiology available on NIMIS		Yes / No	
If no, please attach all reports to referral & arrange for images to be sent via BEAM to St. James's Hospital			

Microbiology

Date:	Sample Type:	Smear
		GeneXpert
		Culture
Date:	Sample Type:	Smear
		GeneXpert
		Culture

Quantiferon Result (If applicable, pls note QFT does not distinguish between active TB disease & Latent TB infection)		
Date:	Nil	
	TB1	
	TB2	
	Mitogen	

Medications

TB Treatment/Medications to date: (if relevant)

Drug	Dose	Start Date
Drug	Dose	Start Date
Drug	Dose	Start Date
Drug	Dose	Start Date
Drug	Dose	Start Date
Other Medications:		
Recent Blood Results attached: Yes No		
Additional Information: Include any investigations arranged or results obtained and any other information you think is relevant:		
Signed:		**Date:**

Please email completed form and relevant attachments to TBreferrals@stjames.ie