IMMIGRATION FURTHERANCE REFERRAL

BC Centre for Disease Control
Provincial Health Services Authority

Vancouver Tel # 604-707-2692
Fax # 604-707-2690

New Westminster Tel # 604-707-2698
Fax # 604-707-2694

REFERRAL TO

☐ **Vancouver TB Clinic,** 655 W12th Avenue ☐ **New Westminster TB Clinic,** 100-237 E Columbia St

REFERRAL FROM

Referring Provider's Name: _____ Date (yyyy/mm/dd):_____

Phone: _____ Fax: _____

CLIENT DEMOGRAPHICS

Name: (Last) _____(First) _____ (Middle)_____

DOB (yyyy/mm/dd):_____ Gender: _____

PHN: _____ Primary Tel#: _____

Address:_____

Interpreter Services Required: ☐No ☐Yes: Language: _____

CLINICAL INFORMATION (must be completed for referral to be processed)

BCG Vaccination: ☐ Unk ☐ No ☐ Yes, date (yyyy/mm/dd): _____

TB exposure/contact history: ☐ Unk ☐ No ☐ Yes, date (yyyy/mm/dd): _____

Previous Skin Test: ☐ Unk ☐ No ☐ Yes, date (yyyy/mm/dd): _____ Result: _____ mm

IGRA History: ☐ Unk ☐ No ☐ Yes, date:_____ Result: ☐ Non-Reactive ☐ Reactive

TB or LTBI treatment history: _____

TB signs and symptoms (specify): _____

Medical History / Medications: _____

_____

REASON FOR REFERRAL (must be completed for referral to be processed)

☐ TB Investigation/TB Specialist Report (602).[1]Clients may be charged for these tests.

Please provide the following information to complete your referral:

- ☐ IGRA/TST results, if available
- ☐ Confirmation of collection of 3 sputum for AFB smear and culture
- ☐ Recent CXR or imaging (within past 3 months)

☐ IGRA/TST Testing (950) for high risk applicants.[2,3] Clients are charged for these tests.

Please indicate the test requested: ☐ IGRA OR ☐ TST

A CXR or imaging within the past 3 months is required to complete your referral.

[1]The TB Specialist Report will include TB physician consult and report indicating diagnosis, treatment recommendations, follow-up requirements and copies of TB diagnostic results.

[2] The IRCC Quality Improvement project requires LTBI testing for high risk applicants.

[3] Close contacts within the previous 5 years; clients with HIV positive serology; clients with a history of head/neck cancer within the past 5 years; clients with advanced CKD or end-stage kidney disease; clients with a solid organ or bone marrow transplant on immunosuppressant therapy.

Office Use Only: Date received: _____ Client ID#_____

Previous TB record: □ YES □ NO