Request for Tuberculosis Screening Information from Primary Care Provider

Client Name:
MRN:
Date of Birth:
Affix client label

Date: _____

Name of primary care provider: _____

Phone number: _____

Fax number: _____

Dear _____,

Your patient is in the process of being waitlisted or registered for:

- ☐ Long-Term Care
- ☐ Facility Respite

An Island Health Registered Nurse has completed the attached Health History for Clients Entering Long-Term Care and/or Facility Respite form, and has found that additional TB screening is required to proceed with the application. Please review at your earliest convenience:

- ☐ Requisition for CXR to rule out TB
- ☐ TB skin test (for clients under 60)

If you have any questions, please contact your patient's CHS clinician:

_____(name) at _____ (contact info)

Thank you,

_____, *Case Manager*