

# OXFORDSHIRE TB SPECIALIST NURSE SERVICE

### REFERRAL FORM FOR CONTACT SCREENING

Referring team:

Referrer signature:

Print full name:

Telephone number:

Email address:

#### Details of the contact to be screened

Name of the contact:

Gender:

NHS no.:

Date of birth (DOB):

Current address:

Post code:

Telephone / mobile number:

#### Ethnicity / language

Country of birth:

Ethnicity:

Interpreter needed: Y / N

First language:

Does the patient speak English? Y / N

#### General Practitioner (GP):

GP Practice name/address:

GP telephone number:

GP email:

Email address:

#### Contact with Index case:

Last contact with Index case (if known):

Relationship with Index case:

Type of contact (household / social / workplace):

Duration of contact (hours / week):

#### If referring children:

Date of any vaccinations received within the last six months or planned within the next three months (if known):

History of BCG vaccination (if known):

#### Significant medical conditions:

Known disabilities:

Currently on medications: Y / N

Known allergies: Y / N

If yes, please indicate:

#### Index case details

Initials:

Age/Gender:

NTBS number:

Diagnosis:

Treatment start date:

Treatment type (Standard,MDS, MDX):

#### Investigations

Smear:

Culture:

PCR:

Sensitivities

Consent to share information with appropriate service: Y / N