CONSULTATION REQUEST: TUBERCULOSIS CONTROL PROGRAM
Phone: 215-685-6873; Fax: 215-685-6477

Requesting Physician: Name _____
Office Telephone No _____ Physician Cell Telephone No. _____
Office Fax: _____ Office Address _____
Date submitted: _____

Patient Information

Name _____ Date of Birth _____
PPD results: _____
CXR: Normal _____ Abnormal (describe):_____
_____
(Please enclose CXR and/or report if available)

Brief Clinical History (include medications, additional diagnoses, and pertinent lab data):

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Specific Questions and Requests for TB Control:

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Recommendations: For Use by TB Control Only –

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Signed: _____ Date: _____ Phone Number _____
Medical Consultant, TB Program