ST VINCENT'S HOSPITAL SYDNEY
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

Tuberculosis/Chest Clinic Referral Form

STRICTLY CONFIDENTIAL

Attention to:

Respiratory/Thoracic Physician

Dr: _____

c/o TB Nurses
St. Vincent's Hospital Chest Clinic
Level 3 Outpatient Department
390 Victoria Street Darlinghurst 2010
Phone:(02) 8382 3694
Email: SVHTBServices@svha.org.au

Respiratory/Thoracic Physicians

Dr Anthony Byrne Dr Yasmeen Al-Hindawi

Dr Ben Kwan

Referral Date:

Patient available for appointment within 10 days?

Yes (Short Notice List) No

Overview:

This form has been designed to streamline the referral process for patients requiring assessment at St Vincent's Hospital Chest Clinic. As a result, all referrals will be formally assessed more quickly and patients are reviewed in a timely manner.

Should you have any questions about this form or the referral process please contact the **TB Nurses at St Vincent's Hospital on 02 8382 3694**.

- Please complete all sections, any questions which are not applicable should be marked as N/A
- When specific results are not available but have been requested please mark as "pending"
- Copies of complete reports of investigations can be attached to the referral form

Referring Specialist:
Name:
Phone:
Fax:
Email:
Phone:
Provider number:

General Practitioner details
Name:
Phone:
Fax:
Email:
Phone:
Provider number:

Referral to service:

Active TB disease ☐ **Latent inactive TB** ☐

Immigration (BUPA) ☐ **Possible TB contact** ☐

Staff/Student ☐ **Other** ☐

Patient details:

Name:	Address:
Date of Birth:	Country of Birth / Previous OS residence:
Preferred name/s:	Mobile:
Sex: Male ☐ Female ☐ Indeterminate ☐	Phone: Work:
Title: Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐	Email:
Australian Status: Permanent Resident ☐ Temporary Visa ☐ Visitor ☐ Other ☐	Aboriginal/Torres Strait Islander: Yes ☐ No ☐
Preferred language:	Interpreter required? Yes ☐ No ☐

Overview referral

Clinical disease course: include details on prior TB exposure or treatments, co-morbid disease including lung disease, Diabetes Mellitus, HIV, Chronic Kidney disease or immunosuppression, previous investigations, rate of decline etc.

History of Tuberculosis Exposure/ Infection / Disease

Previous TB Disease: Yes ☐ No ☐ **If yes: Year of Diagnosis:** _____Country:_____

Drug sensitivities (if known)

Details of treatment: _____

Previous Latent TB Infection: Yes ☐ No ☐ **If yes: Year of Diagnosis:** _____Country:_____

Details of treatment: (if any Rx) _____

Previous known exposure to TB: Yes ☐ No ☐

Mantoux (TST)_____mm

QuantiFERON Gold (IGRA) Pos Neg

Date of Test:

Symptoms experienced

Cough: Yes ☐ No ☐ **If yes:** Dry ☐ Productive ☐ Blood ☐ **Date of onset:**

Fevers: Yes ☐ No ☐ Highest temperature: _____ **Date of onset:**

Night sweats: Yes ☐ No ☐ **Date of onset:**

Weight loss: Yes ☐ No ☐ **If yes**_____kgs lost over _____weeks/months

Lethargy: Yes ☐ No ☐

Loss of appetite Yes ☐ No ☐

Other symptoms: Yes ☐ No ☐ **If yes** please specify_____

Clinical Assessment Please complete all sections

Weight……kgs **Height**……m **BMI**……..

Cyanosed Yes ☐ No ☐ **Oxygen Saturation**……% on AIR

Consider Lymphadenopathy Yes ☐ No ☐ **Details**……..

Clubbed Yes ☐ No ☐

Respiratory rate (at rest):

Chest Auscultation:

Abdominal exam:

Medical History Please complete all sections

Current or previous :		**Details:**
Immunosuppressed	Yes ☐ No ☐	……
Renal Disease	Yes ☐ No ☐	……
Liver Disease	Yes ☐ No ☐	……
Diabetes	Yes ☐ No ☐	……
GI problems	Yes ☐ No ☐	……
Underweight	Yes ☐ No ☐	……
Smoker	Yes ☐ No ☐	

Any other relevant history: Yes ☐ No ☐ **If Yes, Details:**

Family and Social History (Please complete all sections)

Social support available: Yes ☐ No ☐

Accommodation (please tick): **Own** ☐ **Rented** ☐ **Staying with relatives** ☐

Alcohol Yes ☐ No ☐ ……. Unit per week

Previously heavy alcohol intake Yes ☐ No ☐

Previous Illicit Drug use Yes ☐ No ☐ ……. type

Family Medical History:

Microbiology (Please attach sputum results)

Results attached Yes ☐ No ☐ **PENDING** ☐ **(pathology service samples sent to)**

Have the following organisms ever been isolated?

Mycobacteria TB Yes ☐ No ☐ Date……
NTM Yes ☐ No ☐ Date……
Other Yes ☐ No ☐ Date……

Imaging:

Chest x-ray Yes ☐ No ☐ Date performed:

Result……

CT Thorax: Yes ☐ No ☐ Date performed:

Location of Imaging Service……..

Result……

……..

** **Films/CD must accompany patient to first visit clinic****

Current Medications (list or attach print out)

Drug name	Strength	Dose / frequency / special

Allergies: ……

……

Any Other Investigation / Test Results: (detail below or attach)

Please ensure the below are completed:

- o Completed ALL Sections
- o Full past medical history & medication listed or attached
- o Recent pathology attached
- o Patient has a copy of Chest Imaging (CD) for appointment

Your patient will not be booked unless all sections are completed.

The patient will receive a phone call for an appointment.

Signature of Referring Practitioner _____ **Date** _____