New Jersey Department of Health

TB FIELD REFERRAL

Type of Referral: 1 2 3 4 5 6 7 8

Assigned To:

Last Name	First Name	Nickname/AKA

Address	Apt.#/Floor

Telephone No.	Age/Date of Birth	Sex

Race	Height	Size/Build	Other

Additional Information/Remarks (i.e., job, school, recreation, hangouts, language spoken, etc.)

Patient Status:

Case: ☐Pulmonary ☐Non-Pulmonary ☐Inactive

☐Suspect ☐Contact ☐Reactor ☐Alien

Services Required

☐X-Ray ☐Meds ☐DOT ☐MD

☐Sputum ☐TST (Initial/Repeat)

☐Other _____

Medical Provider	Date Missed Appt.	Z Status	# Mo. on Meds

Last Known Bacteriology:

Date Collected: _____ Type Specimen: _____

☐Smear ☐Negative ☐Positive ☐Not Done

☐Culture ☐Negative ☐M. tb ☐Atypical ☐Not Done

Disposition:

☐Received Required Services ☐Refused ☐Died

☐Moved (Enter new address in Remarks) ☐Unable to Locate

☐Reassigned to Another Worker

☐Other (Explain): _____

Initiated By:	Date Assigned:	Target Disposition Date:	Dispositioned By:	Date Dispositioned:

* Numbers correspond to type of referral on Field Activity Report.