



CHEST CLINIC
114 Whitwell Street
Quincy, MA 02169
Tel: (617) 376-5711
Fax : (617) 376-2098

REFERRAL FORM

REFERRING AGENCY: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

PATIENT INFORMATION:

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Country of Birth: \_\_\_\_\_ Language Spoken: \_\_\_\_\_

Interpreter Needed? Yes or No
(if Yes, 48 hour notice is needed)

EVER SEEN AT QMC? Yes or No If yes: QMC MR#: \_\_\_\_\_

Reason for Referral: [ ] Positive PPD [ ] Contact [ ] Other: \_\_\_\_\_

Previous PPD History: Date: \_\_\_\_\_ Results: \_\_\_\_\_

PPD: Date Administered \_\_\_/\_\_\_/\_\_\_ Date Read \_\_\_/\_\_\_/\_\_\_ SIZE: \_\_\_\_\_MM

Is patient symptomatic for: (please circle) cough night sweats weight loss fever
If suspect case, has this been reported? YES/NO

X-RAYS: Date(s): \_\_\_\_\_ Where done: \_\_\_\_\_

\* Please have patient bring current x-ray films to appointment. Please have patient bring in all medications

The visit requires 2 HOURS to complete the process, including chest x-ray, physician exam and laboratory work. A PARENT/GUARDIAN MUST ACCOMPANY ALL PATIENTS UNDER 18 YEARS OF AGE.

APPOINTMENT DATE AND TIME: OFFICE USE ONLY

DAY: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_