



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: _____