WASHINGTON STATE DEPARTMENT OF HEALTH
TUBERCULOSIS CONSULTATION FORM

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Requesting Agency: _____

Staff Member: _____

Telephone: _____ **FAX:** _____

Patient Name: _____ DOB: _____

CLINICAL INFORMATION:

Symptoms: _____

_____

_____

PPD: _____ CXR Results: _____

Mycobacterial Results: _____

Epidemiological Risks and Contact Investigation:

_____

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_____

Nature of Request:

_____

_____

MD Consultant Advise: _____

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