CITY OF LONG BEACH

DEPARTMENT OF HEALTH AND HUMAN SERVICES TB CONTROL PROGRAM
2525 Grand Avenue Long Beach, CA 90815
(562) 570-4526 FAX (562) 570-4391

Referral for TB Screening or Clearance

Instructions for Shelter Staff: Please fill out top part and put this form in an envelope to assure client confidentiality. Ask the client to take the envelope to the clinic/hospital listed in this referral.

Name of referring shelter: _____

Name of shelter contact person: _____ Telephone #: _____

Client's name: _____ Client Date of Birth: _____

Bed location: _____

Date of arrival at shelter: _____ Referral Date: _____

Name of clinic/hospital to which client was referred: _____

☐ Referral for Screening for shelter entrance (complete in 7 days)

☐ Referral for Clearance due to symptoms (Immediate)

Dear Provider:

This client was referred for a TB screening or evaluation, a requirement of all persons staying at this facility.

If referral is for general TB clearance, the form must be completed within 7-days.
If referral is based on symptoms currently present, please evaluate immediately.

To be completed by clinic/hospital physician or nurse (give a copy to client):

☐ Cleared for stay in congregate setting Date of clearance*:_____

☐ Not cleared; pending additional testing/client needs medical follow up.

Clinician Name: _____

Clinic/Hospital Name: _____

** Tests should include the tuberculin skin test (TST) or TB blood tests (QuantiFERON) and/or may also require chest x-ray.*