Referral for Mantoux Test (Tuberculin Skin Test)

Referring clinician details

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

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient details

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

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel No : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare Card No:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interpreter required: Y/N

Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Checklist prior to referring (please tick) – The following information must be provided or else we may be unable to provide the service:**

**Is the patient immunocompromised (HIV/AIDS/immunosuppressive medication etc.)? Yes/ No**

**Any immunisations in the past 4 weeks? If Yes, please attach a list. Yes/No**

**Patient aware that the test requires two clinic visits 2-3 days apart. Yes/No**

**Previous BCG vaccination? Yes/No/Unknown**

**Previous attempts at Mantoux (including unsuccessful attempts) in the past 3 months (list dates):**