NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF TUBERCULOSIS CONTROL

DIRECTLY OBSERVED THERAPY (DOT) REFERRAL FORM

DATE OF REFERRAL: _____/_____/_____

PATIENT INFORMATION

Last Name: _____ First: _____ M.I.: _____

Street Address: _____

City/Borough: _____ State: _____ Zip Code: _____

Home Phone #: _____ Daytime Phone #: _____

Date of Birth: _____/_____/_____ Medical Record Number: _____

REFERRING PHYSICIAN INFORMATION

Referring Facility: _____

Referring Physician: Last Name: _____ First Name: _____

Physician Phone #: _____ Ext: _____ Beeper #: _____

Hours of Operation: _____

Are you an: ❑ Attending; ❑ Resident; ❑ Intern; ❑ Private Practitioner

TREATING PHYSICIAN INFORMATION (Where patient will receive care after discharge if different from above)

TB Treatment Provider Facility Name: _____

Treating MD – Last Name: _____ First Name: _____

MD Phone #: _____ Ext: _____ Beeper #: _____

Primary Health Provider: _____ Phone #: _____
(Facility or MD Name)

CLINICAL INFORMATION

Date Diagnosed: _____/_____/_____

Site(s) of Disease: _____

Other Medical Problems: _____

Non-TB Related Medications: _____ Weight of Patient (lbs): _____

Date of most recent smear: _____/_____/_____ Source: _____ Result: _____

Date of last known culture results: _____/_____/_____ Source: _____ Result: _____

Are susceptibility results known to you? ❑ Yes ❑ No If "No", were they ordered: ❑ Yes ❑ No

If results are known, is there resistance to any anti-tuberculosis medications? ❑ Yes ❑ No

If so, please list: _____

When was effective therapy started? (Effective therapy is defined as treatment with two or more drugs to which a patient's organism is susceptible). Date: _____/_____/_____

What is the current medical regimen?

Medication	Dose	Frequency Daily	Biweekly	Three Times Week	Other
Isoniazid	_____mg	D	D	D	_____
Rifampin	_____mg	D	D	D	_____
Rifabutin	_____mg	D	D	D	_____
Pyrazinamide	_____mg	D	D	D	_____
Ethambutol	_____mg	D	D	D	_____
Vitamin B6	_____mg	D	D	D	_____
Levofloxacin	_____mg	D	D	D	_____
Cycloserine	_____mg	D	D	D	_____
Ethionamide	_____mg	D	D	D	_____
PAS	_____mg	D	D	D	_____
Amikacin	_____mg	D	D	D	_____
Streptomycin	_____mg	D	D	D	_____
Kanamycin	_____mg	D	D	D	_____
Capreomycin	_____mg	D	D	D	_____
Other:	_____mg	D	D	D	_____
	_____mg	D	D	D	_____
	_____mg	D	D	D	_____

Please submit the completed form to the Department of Health and Mental Hygiene, Bureau of Tuberculosis Control's Field Office for the borough in which our facility is located. **Attention** Supervising Public Health Advisor, Field-Based Unit.

Bronx Field Office
1309 Fulton Avenu
Bronx, NY 10456
Tel: (718) 901-6536/7
Fax: (718) 410-0478

Brooklyn Field Office
485 Throop Ave
Brooklyn, NY 112021
Tel: (646) 253-5653
Fax: (646) 253-5691

Manhattan Field Office
346 Broadway, #831
New York, NY 10013
Tel: (212) 442-8410
Fax: (212) 442-8485

Queens Field Office
42-09 28th St. 21st Fl. CN 72B
L.I.C., NY 11101
Tel: (718) 760-0962
Fax: (718) 699-7268

Richmond Chest Center, Staten Island
51 Stuyvesant Place, #408,415
Staten Island, NY 10301
Tel: (718) 983-4530
Fax: (718) 983-4529

DOHMH USE ONLY

Date Referral Received by DOHMH: _____/_____/_____

Medical Reviewer: _____ Appropriate Medication Prescribed?

If no, please state recommendations:

If injections are required, have appropriate provisions been made for them? ❑ Yes ❑ No

Assigned to PHA: _____ PHA #: _____ Date: _____/_____/_____