COUNTY OF ORANGE HEALTH CARE AGENCY
PULMONARY DISEASE SERVICES
CHDP CHEST X-RAY REFERRAL FORM

CLIENTS MUST BE RESIDENTS OF ORANGE COUNTY TO BE ELIGIBLE FOR CHEST X-RAY SERVICES. Clients must present this form completed and signed by the provider to County of Orange Health Care Agency, 1725 W. 17th Street, Room 101E, Santa Ana, CA 92706, (714) 834-8717 or 14120 Beach Boulevard, Room 104, Westminster, CA 92683, (714) 896-7390 in order to receive services. Clinic hours: 8AM to 4PM (closed for lunch 12PM to 1PM). To expedite your visit, appointments are available.

Patient Name (Last, First, Middle): _____

Date of Birth: _____

Parent or Guardian Name(s): _____

Address: _____

Telephone (Home, Work, Cell): _____

Medi-Cal ID#: _____ Issue Date: _____

TUBERCULOSIS SCREENING SUMMARY

Current Positive: ☐ **Tuberculin Skin Test (TST) or** ☐ **Interferon-gamma Release Assay (IGRA)**
Date: _____ If TST, _____mm induration. If IGRA, _____IU/ml units.

Where performed: _____

Previous Result: ☐ **TST or** ☐ **IGRA** ☐ Positive ☐ Negative ☐ Indeterminate
Date: _____ If TST, _____mm induration. If IGRA, _____IU/ml units.

Where performed: _____

Previous Chest X-ray (if applicable):
Date: _____ Result: ☐ Normal ☐ Abnormal ☐ Unknown

Where performed: _____

REFERRING PROVIDER (Physician, Nurse Practitioner, or Physician Assistant):

Name: _____

Address: _____

Telephone: _____ Fax: _____

Normal chest x-ray results will be mailed to the above provider.
Abnormal chest x-ray results will be phoned/faxed to the above provider.
Children under 5 years: The County of Orange Health Care Agency offers treatment for latent tuberculosis infection (LTBI) for this age group. Please indicate below if you wish to refer the child for this service. If yes, please attach documentation of TST or IGRA results.

☐ **YES** ☐ **NO**

Signature of Provider _____ **Date**_____

F042-06.2159 (Rev. 4/16)