

**UTAH DEPARTMENT OF HEALTH  
Tuberculosis Control  
288 North 1460 West Salt Lake City, Utah 84116  
(801) 538-6191**

**REFERRAL & REPORT**

TO: \_\_\_\_\_ FROM: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ PARENT(S) NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TELEPHONE NO: \_\_\_\_\_

DIRECTIONS FOR REACHING PATIENT'S HOME: \_\_\_\_\_

REASON FOR REFFERAL: \_\_\_\_\_

DATE: \_\_\_\_\_ NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

Please enter all identifying information so visit can be made without further check.

Include any scholastic, personality, or environmental information that will be pertinent to the case.

FOR INFORMATION ONLY

REPLY REQUESTED

DATE: \_\_\_\_\_

REPORT OF CONTACT:       Home Visit    Office Visit    Telephone Call

DATE: \_\_\_\_\_ NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_