

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 <u>signed</u> 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) Date: mm induration.	or Interferon-gamma Release Assay (IGRA) If IGRA,IU/ml units.
Where performed:	
Previous Result:	☐ Positive ☐ Negative ☐ Indeterminate If IGRA,IU/ml units.
Where performed:	
Previous Chest X-ray (if applicable): Date: Result: Normal Abnor	mal Unknown
Where performed:	
REFERRING PROVIDER (Physician, Nurse Practitioner, or	r Physician Assistant):
Name:	
Address:	
Telephone:	Fax:
☐ YES	\square NO
Signature of Provider	Date