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**BCG Vaccination Referral Form**

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| **Patient Name:** |  | **DOB:** |  |
| **Address:** |  | **NHS No:** |  |
| **Gender:** |  |
| **Postcode:** |  | **Ethnicity:** |  |
| **Religion:** |  |
| **Contact No:** |  | **Spoken language:** |  |
| **Interpreter required:** |  |
| **GP Address/Telephone No:** |  | | |

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| **Eligibility reasons (please tick):** |

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| --- | --- | --- |
| **Parent/Grandparent born in a country with a high TB rate** |  | **Please specify country** |
|  |
| **Travel to a country with a high TB rate** |  | **Please specify country** |
|  |
| **Born or lived in a country with a high TB rate** |  | **Please specify country** |
|  |
| **TB in a relative or close contact** |  | **Please specify relationship** |
|  |
| **SCID screening** | *Date performed:* | Result: |
| *Reason if not done:* |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referrer**  **Name** |  | **Designation**: |  | **Professional registration No:** |  |
| **Address** |  | **Contact No:** |  | **Date:** |  |

Please send completed form to:

[cathryn.seagrave@wvt.nhs.uk](mailto:cathryn.seagrave@wvt.nhs.uk) For babies 0-12months

[herefordshire.tbservice@nhs.net](mailto:herefordshire.tbservice@nhs.net) for all over 12months