|  |
| --- |
|  |

**BCG Vaccination Referral Form**

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

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

|  |  |  |
| --- | --- | --- |
| **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 For babies 0-12months

herefordshire.tbservice@nhs.net for all over 12months