|  |
| --- |
| **REFERRER - Please check with Child Health if the patient has been vaccinated**  **prior to referring.**  **Child Health telephone number - 01785221151** |

**For Office use only:**

|  |  |
| --- | --- |
| Date received |  |
| Date of clinic appointment |  |
| Correspondence sent |  |

**BCG Vaccination Referral Form**

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

|  |
| --- |
| **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** |
|  |

|  |  |
| --- | --- |
| **Any other comments** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Agreement** | Patient/Parent/Carer is aware of the reason for referral | | | | |
| **Referrer**  **Name** |  | **Designation**: |  | **Professional registration No:** |  |
| **Address** |  | **Contact No:** |  | **Date:** |  |

Please send completed form to: [rwh-tr.TB-nurses@nhs.net](mailto:rwh-tr.TB-nurses@nhs.net)

2021 [BCG Vaccination referral form (master copy).docx](file:///C:\Users\Sukdeep%20Dhadda\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\ZSWQ36KR\BCG%20Vaccination%20referral%20form%20(master%20copy).docx)