|  |
| --- |
| **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

2021 [BCG Vaccination referral form (master copy).docx](file:///C%3A%5CUsers%5CSukdeep%20Dhadda%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CZSWQ36KR%5CBCG%20Vaccination%20referral%20form%20%28master%20copy%29.docx)