Corridor Primary Care Pediatrics
601B Leah Avenue
San Marcos, TX 78666
Phone: (512) 392-1700 Fax: (512) 396-8743

Patient Information

Patient's Name:_____ **DOB:**_____
Gender: ☐ Male ☐ Female
Race: ☐ African-American ☐ White/Hispanic ☐ Asian ☐ Other:_____
Preferred Contact Number: (___) _____

Address: _____
Street City State Zip Code

Preferred email _____

Name(s) of other siblings and Date of Birth *(Put* X if not living in the home with Patient)

_____

_____

_____

Parent(s) or Guardian(s) Information

Mother/Guardian Name: _____ Birth Date:_____
Relationship to Patient: _____
Primary Phone: (___)_____ Secondary Phone: (____) _____
Address if different from above:

_____
Employer:_____ Wk#:_____ Social Security#_____

Father/Guardian Name:_____ Birth Date: _____
Relationship to Patient:_____
Primary Phone: (___)_____ Secondary Phone: (___)_____
Address if different from above:

_____
Employer:_____ Wk#:_____ Social Security#_____

The person(s) listed below have my permission to seek medical attention for my child at Corridor Primary Care Pediatrics

Name	Relationship to Child	Phone Number:
Name	Relationship to child	Phone Number:
Name	Relationship to child	Phone Number :

The info1mation that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my minor/child's medical status.

Date:_____ Signature_____

Print Name_____ Referred to our office by:_____

Tuberculosis (TB) Questionnaire for Children

Name of Child _____ Date of Birth _____

Organization administering questionnaire _____ Date _____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) or a TB blood test (called an IGRA) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box	**Yes**	**No**	**Don't Know**
TB can cause a fever of long duration, unexplained weight loss, a cough (lasting over two weeks), or coughing up blood. **As far as you know has your child:** • been around anyone with any of these symptoms or problems? or • had any of these symptoms or problems? or • been around anyone sick with TB?			
Was your child born in: Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to: Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries:			
To your knowledge, has your child spent time (longer than 3 weeks) with: anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? ☐ Yes (specify date ____/____/_____) ☐ No
Has your child ever had a positive TB skin test? ☐ Yes (specify date ____/____/_____) ☐ No
Has your child ever had a positive TB blood test? ☐ Yes (specify date ____/____/_____) ☐ No

For school/healthcare provider use only

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PPD / IGRA administered (circle one)

Date Administered: _____/_____/_____ Date Read (if PPD): _____/_____/_____

Result of PPD: _____ mm Result of IGRA test: ☐ Positive ☐ Negative ☐ Indeterminate/Invalid

Type of service provider (i.e. school, Health Steps, other clinics): _____

PPD/IGRA provider: _____ _____
signature printed name

Provider phone number: _____

City _____ County _____

If positive, referral to healthcare provider: ☐ Yes ☐ No

If yes, name/contact of provider: _____