

WASHINGTON STATE DEPARTMENT OF HEALTH
TUBERCULOSIS CONSULTATION FORM
Scott Lindquist MD, MPH
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Requesting Agency: _____

Staff Member: _____

Telephone: _____ FAX: _____

Patient Name: _____ DOB: _____

CLINICAL INFORMATION:

Symptoms: _____

PPD: _____ CXR Results: _____

Mycobacterial Results: _____

Epidemiological Risks and Contact Investigation:

Nature of Request: _____

MD Consultant Advice: _____

