



Medical Director  
Larry Wile, Jr, MD

**Positive PPD Referral Form**

Name: Last		First:		Mid:	
Address:			Apt. / Lot #		Phone:
City:		State:		Zip:	County:
Date of Birth:	Age:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Other Contact Name/ Phone	
Employer:					

Date PPD placed: \_\_\_\_\_

Date PPD read: \_\_\_\_\_

PPD Size (measure only induration, in millimeters) \_\_\_\_\_mm

IGRA Teat Result \* Please Fax with Referral

**If available**, AST laboratory result \_\_\_\_\_ units/L on \_\_\_\_\_ date

**If available**, ALT laboratory result \_\_\_\_\_ units/L on \_\_\_\_\_ date

**If available, attach CXR (Chest X-Ray) Result**

**TO REPORT:** please copy this form & give to the patient to bring with them,

also **\*FAX a copy to the proper county:** **Van Buren FAX:** 269.621.2725

**Cass FAX** 269.782.0121

If a Public Health Nurse needs to be contacted, please call:

Van Buren County: 269.621.3143 Extension 0, ask for the Public Health Nurse on duty

Cass County: 269.782.0064 Extension 2015

Note that completion of this form is mandatory for referral processing.

