

VANCOUVER GENERAL HOSPITAL
Nontuberculous Mycobacterial (NTM) Disease Clinic Referral Form
PROVIDER-TO-PROVIDER CONSULT REQUEST

7th Floor Station 1A - 2775 Laurel St. Diamond Health Centre, Vancouver, BC, CA, V5Z 1M9
Phone: 604-875-4775 **Fax:** 778-504-9776 **Email:** vghntm@vch.ca

Please complete this referral form to initiate a provider-to-provider consult request for patients with NTM disease. The referring provider will be contacted by the clinic physician at the requested day/time. Please note that call-backs are intended to be within 1-2 business days, however wait-times may vary depending on clinic availability. Clinic hours are Mondays to Fridays, 8 am - 4 pm, excluding holidays.

Today's Date: _____

PATIENT DEMOGRAPHICS	
Patient Name:	PHN:
DOB:	MRN:
Address:	
REFERRING PROVIDER DETAILS	
Provider Name:	MSP Billing #:
Provider Call-Back Number:	Fax Number:
Best Time/Day to Call:	
REFERRAL DETAILS	
Reason for Referral:	
Urgency: <input type="checkbox"/> Urgent <input type="checkbox"/> Routine	
Is this a new or follow-up VGH NTM provider-to-provider consult? <input type="checkbox"/> New <input type="checkbox"/> Follow-up	
Please fill in the following eligibility criteria:	
<input type="checkbox"/> Pulmonary: <ul style="list-style-type: none"> <input type="checkbox"/> CT chest consistent with NTM pulmonary disease <u>AND</u> <input type="checkbox"/> At least one positive culture for NTM from a respiratory source (sputum, bronchoscopy, or tissue) 	
OR	
<input type="checkbox"/> Extrapulmonary: <ul style="list-style-type: none"> <input type="checkbox"/> At least one positive culture for NTM from any non-respiratory source <input type="checkbox"/> Any relevant imaging (CT not required) 	
<i>*Please note that referrals for suspected/confirmed tuberculosis or leprosy will be declined.</i>	
Is the patient currently receiving antibiotic treatment for NTM disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the patient received antibiotic treatment for NTM disease in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please outline the previous treatment history, including antibiotic regimen(s) and history of medication intolerance and/or toxicity:	
Additional information or specific question(s) for consult:	
Documentation Required:	<ul style="list-style-type: none"> • Brief history and physical report, including additional chronic health issues • Relevant specialist consults and documentation from follow-ups • Pertinent results, including lab/microbiology, ECG and radiology reports • Medications and allergies