University Health Network Nontuberculous Mycobacteria (NTM) Referral Form
Toronto Western Hospital and West Park Healthcare Centre
Fax: 416-603-5375 / Fax: 416-243-3696

PLEASE note and inform the patient, they may see ANY of the following physicians based on availability:
Dr. Sarah Brode, Dr. Jessica Kapralik, Dr. Ted Marras, Dr. Shazmeen Manji or Dr Howard Song

PATIENT DEMOGRAPHICS	
Patient Name:	**OHIP:**
DOB:	**MRN:**
Address:	**Postal Code**
Phone Numbers: Home: Cellphone: Work: **Please indicate preferred contact number*	
Please note that the patient will be seen at either of the West Park or Toronto Western sites depending on relative waiting list times	
Interpreter required? ◯ YES ◯ NO Specify language:	
REFERRAL DETAILS	
Reason for Referral:	
Urgency: ◯ Urgent ◯ Routine	
Please fill in the following eligibility criteria: ◯ Pulmonary: ◯ CT chest consistent with NTM pulmonary disease (*date** _____) AND ◯ At least one respiratory (sputum, bronchoscopy, tissue) culture growing NTM (*date** _____) ◯ Have you requested antimicrobial drug susceptibility testing? OR ◯ Extrapulmonary: ◯ At least one positive culture for NTM from any non respiratory source ◯ Any relevant imaging ****Please provide the date (YY/MM) of the most recent CT and culture*** ******Referrals for suspected/confirmed TB will be redirected to TB clinic******	
Has the patient received antibiotic treatment for NTM disease in the past? ◯ YES ◯ NO If yes, please outline previous treatment history, including antibiotic regimen(s), intolerance and/or toxicity:	
Is the patient currently receiving antibiotic treatment for NTM disease? ◯ YES ◯ NO *List (drugs, doses and frequency):*	
Additional information or specific question(s) for consult:	
Documentation required: Brief history and physical report, including other medical issues. Relevant specialist consults and documentation from follow ups. Relevant results including lab/microbiology, radiology reports, ECG and drug susceptibility test reports. Medications and allergies.	
Referring Provided Details	
Provider Name:	**Billing Number:**
Phone Number:	**Fax Number:**

Please note incomplete referrals will delay booking. When the referral has been reviewed, your patient will be notified. If we are unable to contact the patient or if the referral is declined, we will notify your office accordingly.