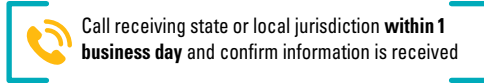


# Interjurisdictional TB Notification

Active/Evaluation for Possible TB Disease

PAGE 1 OF 2

Referred for:  TB disease continued care  
 TB disease evaluation



Date of Expected Arrival:

## Client Information

Last Name:  First Name:  Middle Name:

Date of Birth:  Sex at Birth:  Gender Identity:  Race:  Ethnicity:

Country of Birth:  Primary Language:  Interpreter Needed?

New Address:  City:

State/Province/Region:  Zip Code:  County:

Phone 1:  Phone 2:  Email:

Immigrant/Refugee Classification  EDN A#  Transfer Complete in EDN

Alternate Contact Name:  Relationship:  Phone:

Additional Contact Information:

Diagnosis Verified by:  Site of Disease:  Specify extrapulmonary:

If Pulmonary:  Cavitory  Sputum culture conversion documented Date of first negative sputum culture:

Isolation:  Discontinued  Continued isolation necessary, specify:

RVCT (Case Report) Attached (required if counted):  Yes  No

Tests/Results: <sup>i</sup> TST/IGRA:  Radiology:  Smear(s):  NAAT:

Most recent results are attached  
(If not attached, please provide reason)

Culture(s):  Susceptibilities (if culture positive):

Treatment Summary: MAR/DOT Log Attached:

Drug:  Dosage:  Therapy Admin:  Date Started:  Date Stopped:

Drug:  Dosage:  Therapy Admin:  Date Started:  Date Stopped:

Drug:  Dosage:  Therapy Admin:  Date Started:  Date Stopped:

Drug:  Dosage:  Therapy Admin:  Date Started:  Date Stopped:

Drug:  Dosage:  Therapy Admin:  Date Started:  Date Stopped:

Drug:  Dosage:  Therapy Admin:  Date Started:  Date Stopped:

Current Medication Administration Method:  DOT  eDOT  SAT

Side Effects, Adherence, or Administration Problems:

Estimated Treatment Duration:  Last DOT dose administered on:

Date medication given for travel:  # of doses in hand for travel:  Prescription Given:

Comments:

# Interjurisdictional TB Notification Follow-Up

Active/Evaluation for Possible TB Disease

PAGE 2 OF 2

## Client Information

Last Name:

First Name:


Date of Birth:

## Follow-Up Information

Report Status:  Date of Disposition:  Reason Dispositioned:

If Disposition Other:

Evaluation:  Evaluation Outcome:

**Tests/Results:**  Most recent results are attached  
(If not attached, please provide reason)

TST/IGRA:  Radiology:  Smear(s):  NAAT:   
Culture(s):  Susceptibilities (if culture positive):

**Treatment Status:**  MAR/DOT Log Attached:  If not completed, provide reason:

**If Active TB Disease:** Counting Jurisdiction:  RVCT#

**If Patient Moved:** Notified New Jurisdiction:

New Address:  City:

State/Province/Region:  Zip Code:  County:

Phone 1:  Phone 2:  Email:

## Comments: