Interjurisdictional TB Notification Cover Sheet

Send with All Referrals/Follow-up

Type of Referral:
- ☐ **Active/Possible TB**
- ☐ **TB Contact**
- ☐ **TB Infection**

→ Call receiving state or local jurisdiction **within 1 business day** and confirm information is received

Online directory of state, big city and territory TB programs: **www.nationaltbcoalition.org/tb-program-contacts/**

NTCA Recognized Standard for Communication of the IJN Form:

The recommended workflow for the secure transmission of the IJN and additional guidance on completing and sending the IJN Form and Follow-Up is provided in the IJN Companion Guide: **https://bit.ly/interjurisdictional-notifications**

Referring
- **Local Jurisdiction**

INITIAL

Name of Local Program: _____ City: _____

County: _____ State: _____

Local Program Contact: _____ Phone: _____ Date sent to Referring State: _____

☐ Fax: _____ ☐ Email: _____

Check box above for preferred document transmission.

FOLLOW UP

Referring
- **State**
- **Big City**
- **Territory**

INITIAL

Name of Program: _____ Jurisdiction: _____

Program Contact: _____ Phone: _____ Date sent to Receiving State/ Big City/Territory: _____

☐ Fax: _____ ☐ Email: _____

Check box above for preferred document transmission.

FOLLOW UP

Receiving
- **State**
- **Big City**
- **Territory**

INITIAL

Name of Program: _____ Jurisdiction: _____

Program Contact: _____ Phone: _____ Date sent to Receiving Local: _____

☐ Fax: _____ ☐ Email: _____

Check box above for preferred document transmission.

FOLLOW UP

Receiving
- **Local Jurisdiction**

Name of Local Program: _____ City: _____

County: _____ State: _____

Local Program Contact: _____ Phone: _____

☐ Fax: _____ ☐ Email: _____

Follow-Up sent to:
- ☐ Receiving State/Big City
- ☐ Referring State/Big City
- ☐ Referring Local

Date Follow-Up sent: _____

Check box above for preferred document transmission.

NTCA National Tuberculosis Coalition of America

National Tuberculosis Coalition of America (NTCA)
- National Tuberculosis Nurse Coalition (NTNC)
- Society for Epidemiology in TB Control (SETC)

https://bit.ly/interjurisdictional-notifications

NOTE: This form contains confidential patient information. Please comply with HIPAA regulations when sending this form. | Rev: 3/2026

Interjurisdictional TB Notification

Active/Evaluation for Possible TB Disease

Referred for: ☐ **TB disease continued care** ☐ **TB disease evaluation**

Call receiving state or local jurisdiction **within 1 business day** and confirm information is received

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: Character limit: 125

Diagnosis Verified by: | Site of Disease: | Specify extrapulmonary:

If Pulmonary: ☐ Cavitary ☐ 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:
Most recent results are attached
(If not attached, please provide reason)

TST/IGRA: | Radiology: | Smear(s): | NAAT:

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: Character limit: 350

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Interjurisdictional TB Notification Follow-Up

Active/Evaluation for Possible TB Disease

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:

Character limit: 2000

Interjurisdictional TB Notification

TB Contact Investigation

Referral Reason: ◯ Location, evaluation ◯ Completion of evaluation (evaluation initiated, but the person moved)

Date of Expected Arrival:

Referred for: ☐ Individual contact ☐ Expanded contact group

Referring TB Program requests Follow-Up Information returned: (check all that apply) ☐ Preliminary ☐ Final ☐ See Comments below

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:

Alternate Contact Name: | Relationship: | Phone:

Date of Last Exposure: | Contact Priority: | Type of Contact:

☐ Index Case Sputum Smear Positive ☐ Index Case Sputum NAAT/Culture Positive ☐ Index Case Cavity on Radiology Index Case Drug Resistant:

Initial TB Test: | Date: | Result: | TST mm: | Report Attached:

8+ week Post-exposure Test: | Date: | Result: | TST mm: | Report Attached:

Radiology: ◯ Yes | ◯ No | Report Attached:

Treatment Status: | MAR/DOT Log Attached:

Starting TB Infection Regimen: | Date Started: | Estimated Treatment Duration:

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

Side Effects, Adherence, or Administration Problems:

Comments:

Character limit: 1500

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Interjurisdictional TB Notification

TB Contact Investigation

Client Information

Last Name: | First Name: | Date of Birth:

Follow-Up Information

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All test results pertaining to TB/LTBI evaluation must be attached. This is especially important for provider diagnosed or clinical cases and persons for whom evaluation is still ongoing.

Date of Disposition: | Reason Dispositioned:

If

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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: | Completing TB Infection Regimen: | Date Stopped:

If Patient Moved: Notified New Jurisdiction:

New Address: | City:

State/Province/Region: | Zip Code: | County:

Phone 1: | Phone 2: | Email:

Comments:

Character limit: 2250

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Interjurisdictional TB Notification

TB Infection Continued Care (Not a Contact)

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: Character limit: 125

Treatment Status: ☐ **Verified treatment services at receiving jurisdiction**

Starting TB Infection Regimen: | Date Started: | Estimated Treatment Duration:

Date medication given for travel: | # of doses in hand for travel: | Prescription Given: | MAR/DOT Log Attached:

Side Effects, Adherence, or Administration Problems:

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

TST/IGRA: | Radiology: | Smears and Cultures:

Comments: Character limit: 350

Follow-Up Information

Report Status: | Date of Disposition: | Reason Dispositioned:

Treatment Status: | MAR/DOT Log Attached:

Completing TB Infection Regimen: | Date Stopped:

If Patient Moved: Notified New Jurisdiction:

New Address: | City:

State/Province/Region: | Zip Code: | County:

Phone 1: | Phone 2: | Email:

Comments: Character limit: 350

