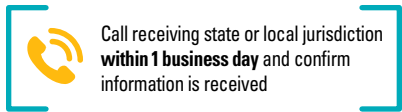


Interjurisdictional TB Notification Cover Sheet

Send with All Referrals/Follow-up

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

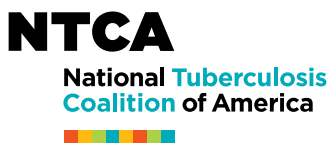


Online directory of state, big city and territory TB programs: www.nationaltbcoalition.org/tb-program-contacts/

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	Name of Local Program: <input type="text"/> City: <input type="text"/> County: <input type="text"/> State: <input type="text"/> Local Program Contact: <input type="text"/> Phone: <input type="text"/> <input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/> <i>Check box above for preferred document transmission.</i>	Date sent to Referring State: <input type="text"/>
Referring • State • Big City • Territory	Name of Program: <input type="text"/> Jurisdiction: <input type="text"/> Program Contact: <input type="text"/> Phone: <input type="text"/> <input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/> <i>Check box above for preferred document transmission.</i>	Date sent to Receiving State/Big City/Territory: <input type="text"/>
Receiving • State • Big City • Territory	Name of Program: <input type="text"/> Jurisdiction: <input type="text"/> Program Contact: <input type="text"/> Phone: <input type="text"/> <input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/> <i>Check box above for preferred document transmission.</i>	Date sent to Receiving Local: <input type="text"/>
Receiving • Local Jurisdiction	Name of Local Program: <input type="text"/> City: <input type="text"/> County: <input type="text"/> State: <input type="text"/> Local Program Contact: <input type="text"/> Phone: <input type="text"/> <input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/> <i>Check box above for preferred document transmission.</i>	Follow-Up sent to: <input type="checkbox"/> Receiving State/Big City <input type="checkbox"/> Referring State/Big City <input type="checkbox"/> Referring Local Date Follow-Up sent: <input type="text"/>



National Tuberculosis Coalition of America (NTCA)

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

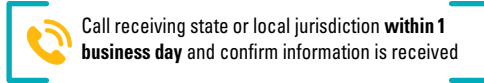
<https://bit.ly/interjurisdictional-notifications>

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: ⁱ 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:

Interjurisdictional TB Notification

TB Contact Investigation

PAGE 1 OF 2

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: ⁱ 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:
&+ 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:

Interjurisdictional TB Notification

TB Contact Investigation

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: i TST/IGRA: Radiology: Smear(s): NAAT:
Most recent results are attached
(If not attached, please provide reason) 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:

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:

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: i

TST/IGRA: Radiology: Smears and Cultures:

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

Comments:

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: