# 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:

**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: |
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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



### 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:**



**NOTE:** This form contains confidential patient information. Please comply with HIPAA regulations when sending this form. | Rev: 3/2024