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:

Most recent results are attached

(If not attached, please provide reason)

TST/IGRA: Radiology: Smears and Cultures:

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:

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