CureTB Transnational Notification

Division of Global Migration Health | E-mail: curetb@cdc.gov | Telephone: 619-542-4013
Web address: www.cdc.gov/cureTB

OMB APPROVED CONTROL
NO 0920-1186
EXP DATE: 4/30/2024

[1]Referring Jurisdiction: _____ (City) _____ (County) _____ (State) [1]Date sent: _____

[1]Contact person: _____ [1]Telephone: _____ Ext: _____ Fax: _____

Referring Agency: _____ E-Mail Address: _____

☐ Verified TB: ☐ RVCT: _____ (Year Reported) – _____ (State) – _____ (9 digits/letters) or ☐ Not reported

☐ ICE A#: _____ ☐ BOP#: _____ – _____

☐ Suspected TB ☐ Clinical History request (specify year): _____ ☐ Immunocompromised (specify): _____

A. Patient

[1]Name: _____ (Paternal) _____ (Maternal)

_____ (First) _____ (Middle)

Sex: ☐ M ☐ F Alias: _____ DOB: _____

Email 1: _____ Email 2: _____

☐ Check if patient/parent not currently at home. Current location: _____ Telephone: _____

B. Info in U.S.

Address: _____ (Street) _____ (Apt) _____ (City)

_____ (County) _____ (State) _____ (Zip code) Home Phone: _____ Cell: _____

Contact person in the U.S.

Name: _____ Home Phone: _____ Cell: _____

Relationship: _____ Email: _____

C. Destination Country

Address: _____ (Street)

_____ (Apt) _____ (City) _____ (County)

_____ (State) _____ (Zip code) _____ (Country)

Contact person at destination

Name: _____ Home Phone: _____ Cell: _____

Relationship: _____ Email: _____

D. Clinical Information

Information for: ○ this referred patient ○ Other, specify: _____

Site(s) of disease: ☐ Pulmonary ☐ Other(s), specify: _____

☐ HIV ☐ Diabetes ☐ No Symptoms ☐ Symptoms, specify:

[1] Fields required to initiate the referral process
[2] Please send imaging and laboratory reports as attachments
[3] Please attach additional information, as needed
[4] Please contact us via phone to confirm your referral was received

[1]Name: _____ _____
Paternal Maternal

_____ _____
First Middle

Sex: ☐ M ☐ F DOB: _____

☐ Verified TB: ☐ RVCT: _____ – _____ – _____ or ☐ Not reported
Year Reported State (9 digits/letters)

☐ ICE A#: _____ ☐ BOP#: _____ – _____

☐ Suspected TB ☐ Clinical History request (specify year): _____ ☐ Immunocompromised (specify): _____

[2]Date of collection	[2]Specimen type	[2]Smear	Culture	Susceptibility

Other tests (specify): _____

[2]Imaging

Date	[2]Imaging

E. Medication

For: ◯ this referred patient ◯ Not started Reason for not started: _____

Drug	Dose	Start date	Stop date

Expected move date: _____ Patient given _____ days of medication.

Comments:

[1] Fields required to initiate the referral process
[2] Please send imaging and laboratory reports as attachments
[3] Please attach additional information, as needed