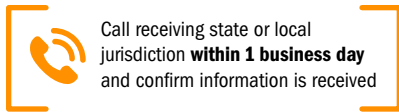


Interjurisdictional TB Notification Cover Sheet

Send with All Referrals/Follow-up

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



Online directory of state and big city TB programs: www.tbcontrollers.org/community/statecityterritory/

NTNC/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: www.tbcontrollers.org/resources/interjurisdictional-transfers/

<h3 style="margin: 0;">Referring</h3> <ul style="list-style-type: none"> • Local Jurisdiction 	<p>Name of Local Program: <input type="text"/> City: <input type="text"/></p> <p>County: <input type="text"/> State: <input type="text"/></p> <p>Local Program Contact: <input type="text"/> Phone: <input type="text"/></p> <p><input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/></p> <p><i>Check box above for preferred document transmission.</i></p> <p style="text-align: right;">Date sent to Referring State: <input type="text"/></p>
INITIAL	FOLLOW UP
<h3 style="margin: 0;">Referring</h3> <ul style="list-style-type: none"> • State • Big City • Territory 	<p>Name of Program: <input type="text"/> Jurisdiction: <input type="text"/></p> <p>Program Contact: <input type="text"/> Phone: <input type="text"/></p> <p><input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/></p> <p><i>Check box above for preferred document transmission.</i></p> <p style="text-align: right;">Date sent to Receiving State/Big City/Territory: <input type="text"/></p>
INITIAL	FOLLOW UP
<h3 style="margin: 0;">Receiving</h3> <ul style="list-style-type: none"> • State • Big City • Territory 	<p>Name of Program: <input type="text"/> Jurisdiction: <input type="text"/></p> <p>Program Contact: <input type="text"/> Phone: <input type="text"/></p> <p><input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/></p> <p><i>Check box above for preferred document transmission.</i></p> <p style="text-align: right;">Date sent to Receiving Local: <input type="text"/></p>
INITIAL	FOLLOW UP
<h3 style="margin: 0;">Receiving</h3> <ul style="list-style-type: none"> • Local Jurisdiction 	<p>Name of Local Program: <input type="text"/> City: <input type="text"/></p> <p>County: <input type="text"/> State: <input type="text"/></p> <p>Local Program Contact: <input type="text"/> Phone: <input type="text"/></p> <p><input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/></p> <p><i>Check box above for preferred document transmission.</i></p> <p style="text-align: right;">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"/></p>



National Tuberculosis Nurse Coalition (NTNC)
 Society for Epidemiology in TB Control (SETC)
 National Tuberculosis Controllers Association (NTCA)

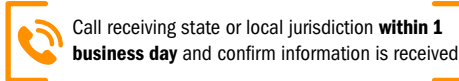
www.tbcontrollers.org/resources/interjurisdictional-transfers

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: 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: 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:  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: 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: