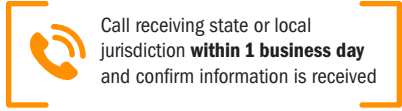


Interjurisdictional TB Notification Cover Sheet

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.tbcontrollers.org/community/statecityterritory/

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>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>Date sent to Referring State: <input type="text"/></p>
<h3>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>Date sent to Receiving State/Big City/Territory: <input type="text"/></p>
<h3>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>Date sent to Receiving Local: <input type="text"/></p>
<h3>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>Follow-Up sent to:</p> <p><input type="checkbox"/> Receiving State/Big City</p> <p><input type="checkbox"/> Referring State/Big City</p> <p><input type="checkbox"/> Referring Local</p> <p>Date Follow-Up sent: <input type="text"/></p>



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

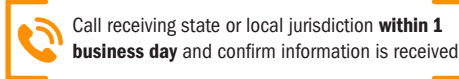
www.tbcontrollers.org/resources/interjurisdictional-transfers

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: 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: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>
Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>
Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>
Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>
Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>

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:

Interjurisdictional TB Notification

TB Contact Investigation

Date of Expected Arrival:

Referred for: Location, evaluation Completion of evaluation (evaluation initiated, but the person moved)

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:** **Drug Resistant Index Case:**

Initial TB Test: **Date:** **Result:** **TST mm:** **Report Attached:**

8+ 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:

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:** **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: 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:

Tests/Results:  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: