CureTB Transnational Notification

OMB Approved

Control No 0920-XXXX

Exp Date: XX/XX/XXXX

Telephone: (619) 542-4013 Fax: (404) 471-8905

Centers for Disease Control and Prevention

Division of Global Migration and Quarantine

E-Mail: curetb@cdc.gov

 ¹Referring Jurisdiction: ¹Date sent:

 City County State

 ¹Contact person: ¹Telephone: Ext. Fax:

 Referring Agency: E-Mail Address:

 [ ]  Verified TB: [ ]  RVCT#: or  [ ]  Not reported [ ]  ICE A#  [ ]  BOP#

 [ ]  Suspected TB [ ]  Clinical History request (s*pecify year)*: [ ]  Immunocompromised (*specify)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient**

 ¹**Name**: Sex: [ ]  M [ ]  F

 Paternal Maternal First Middle

 Alias: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail:

 [ ]  Check if patient/parent not currently at home. Current location: Tel.:

**Info. in U.S.**

 Number Street Apt City

 Home Phone: Cell:

 County State Zip code

Contact person in the U.S.: Name: Home Phone: Cell:

Relationship:

**Destination Country**

 Number Street Apt   City

 **Country:**

 County State Zip code

 Contact person at destination: Name: Home Phone: Cell:

 Relationship: Home Phone: Cell:

**Clinical Information**

**Information for:** [ ]  this referred patient  [ ]  Other, specify:

 Site (s) of disease: [ ]  Pulmonary  [ ]  Other (s) specify:

 [ ]  HIV [ ]  Diabetes [ ]  No Symptoms [ ]  Symptoms, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 2**Date of collection** | 2**Specimen type** | 2**Smear** | **Culture** | **Susceptibility** | **Date** | **2Imaging** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

 **Other tests** (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Comments:**

**Medication**

 **For:** [ ]  this referred patient [ ]  Not started

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.  An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number.  Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-XXXX

|  |  |  |  |
| --- | --- | --- | --- |
| Drug | Dose | Start date | Stop date |
|  |  |  |  |
|  |  |  |  |
|  |  |  | Expected move date: **\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient given days of medication. |
|  |  |  |  |
|  |  |  |  |