OMB Approved
Control No
0920-XXXX
Exp Date:

CureTB Transnational Notification

Centers for Disease Control and Prevention
Division of Global Migration and Quarantine
E-Mail: curetb@cdc.gov

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

[1]Referring Jurisdiction: ______________________________ [1]Date sent: __________

City County State

[1]Contact person: ______________________ [1]Telephone: ____________ Ext. _____ Fax: ____________

Referring Agency: ____________________ E-Mail Address: ______________________________

☐ Verified TB: ☐ RVCT#: ______________ or ☐ Not reported ☐ ICE A# ___________ ☐ BOP# __________
☐ Suspected TB ☐ Clinical History request (*specify 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	[2]Imaging

Other tests (specify): ______________________________

Medication

For: ☐ this referred patient ☐ Not started

Drug	Dose	Start date	Stop date

Expected move date: ______________

Patient given __________ days of medication.

Comments:

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