



CureTB Transnational Notification

Division of Global Migration and Quarantine | E-mail: curetb@cdc.gov | Telephone: 619-542-4013 | Fax For California: 619-692-8020 | Fax For other areas: 404-471-8905 | Web address: www.cdc.gov/usmexicohealth/curetb.html

¹Referring Jurisdiction: _____ ¹Date sent: _____
City County State

¹Contact person: _____ ¹Telephone: _____ Ext. _____ Fax: _____

Referring Agency: _____ E-Mail Address: _____

Verified TB: RVCT#: - - or Not reported
Year reported State (9 digits/letters)

ICE A# _____ BOP# -

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

A. Patient

¹Name: _____ Sex: M F
Paternal Maternal First Middle

Alias: _____ DOB: _____ E-Mail: _____

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

B. Info in U.S.

Number _____ Street _____ Apt _____ City _____
County State Zip code

Home Phone: _____ Cell: _____

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

Relationship: _____ E-Mail: _____

C. Destination Country

Number _____ Street _____ Apt _____ City _____
County State Zip code

Country: _____ State: _____

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

Relationship: _____ E-Mail: _____

D. 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

Other tests (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

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

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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



Name: _____ Sex: M F

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ICE A# _____ BOP# -

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2Imaging

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:

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