OMB APPROVED CONTROL
NO 0920-1186 EXP DATE:
06/30/2020

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

[1]Referring Jurisdiction: _____ (City) _____ (County) _____ (State) [1]Date sent: _____

[1]Contact person: _____ [1]Telephone: _____ 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

[1]**Name**: _____ (Paternal) _____ (Maternal) _____ (First) _____ (Middle) Sex: ☐ M ☐ F

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

REVISED 10/2019

OMB Approved
Control No
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Exp Date:

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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

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

☐ ICE A# _____ ☐ BOP# ☐☐☐☐☐☐☐ - ☐☐☐

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

[2]Imaging

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:

1 Fields required to initiate the referral process

2. Please send imaging and laboratory reports as attachments

3. Please attach additional information, as needed

REVISED 10/2019