



# 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

<sup>1</sup>Referring Jurisdiction: \_\_\_\_\_ <sup>1</sup>Date sent: \_\_\_\_\_  
City County State

<sup>1</sup>Contact person: \_\_\_\_\_ <sup>1</sup>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**  
<sup>1</sup>Name: \_\_\_\_\_ 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: \_\_\_\_\_

<sup>2</sup> Date of collection	<sup>2</sup> Specimen type	<sup>2</sup> 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](mailto: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): \_\_\_\_\_

2Imaging

Date	<sup>2</sup> 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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