



# CureTB Transnational Notification

Division of Global Migration Health | E-mail: [curetb@cdc.gov](mailto:curetb@cdc.gov) | Telephone: 619-542-4013  
Web address: [www.cdc.gov/cureTB](http://www.cdc.gov/cureTB)

OMB APPROVED CONTROL  
NO 0920-1186  
EXP DATE: 2/29/2024

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

<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: \_\_\_\_\_ Paternal \_\_\_\_\_ Maternal \_\_\_\_\_

First \_\_\_\_\_ Middle \_\_\_\_\_

Sex: M F Alias: \_\_\_\_\_ DOB: \_\_\_\_\_

Email 1: \_\_\_\_\_ Email 2: \_\_\_\_\_

Check if patient/parent not currently at home. Current location: \_\_\_\_\_ Telephone: \_\_\_\_\_

## B. Info in U.S.

Address: \_\_\_\_\_ Street \_\_\_\_\_ Apt \_\_\_\_\_ City \_\_\_\_\_

County \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

### Contact person in the U.S.

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Relationship: \_\_\_\_\_ Email: \_\_\_\_\_

## C. Destination Country

Address: \_\_\_\_\_ Street \_\_\_\_\_

Apt \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_

State \_\_\_\_\_ Zip code \_\_\_\_\_ Country \_\_\_\_\_

### Contact person at destination

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Relationship: \_\_\_\_\_ Email: \_\_\_\_\_

## 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>1</sup> Fields required to initiate the referral process

<sup>2</sup> Please send imaging and laboratory reports as attachments

<sup>3</sup> Please attach additional information, as needed

<sup>4</sup> Please contact us via phone to confirm your referral was received

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<sup>3</sup> Please attach additional information, as needed