



CureTB Transnational Notification

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

Division of Global Migration Health | E-mail: $\underline{curetb@cdc.gov} \ | \ Telephone: 619-542-4013$ Web address: $\underline{www.cdc.gov/cureTB}$

| Referring Jurisdiction: | County | State | | _ Date sent: |
|---|----------|------------------------|----------|--------------------|
| 'Contact person: | · | State | Ext: | _ Fax: |
| Referring Agency: | | | | |
| | | | | |
| Year Reported State | | | | |
| ICE A#: | BOP#: | | | |
| Suspected TB Clinical History request (specify year): A. Patient | lmmunoo | compromised (specify): | | |
| | | | | |
| ¹ Name: | | | Maternal | |
| First | | | Middle | |
| Sex: M F Alias: | | | | DOB: |
| Email 1: | Email 2: | | | |
| Check if patient/parent not currently at home. Current location:_ | | | Telepl | hone: |
| B. Info in U.S. | | | | |
| Address:Street | | Apt | | City |
| | | Home Phone: | | Cell: |
| County State Contact person in the U.S. | Zip code | | | |
| Name: | _ | Home Phone: | | Cell: |
| Relationship: | | Email: | | |
| C. Destination Country | | | | |
| Address: | Street | | | |
| | Street | | | |
| Apt City | | | County | |
| Contact person at destination | Zip code | | Country | |
| 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, spec | | | | |
| | • | | | |

¹ Fields required to initiate the referral process

² Please send imaging and laboratory reports as attachments

³ Please attach additional information, as needed

⁴ Please contact us via phone to confirm your referral was received

CS347315-A 02/01/2024

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 0920-1186

| ¹ Name: | Paternal | | Maternal | | | | |
|--|---|--------------------|--------------|----------------|--|--|--|
| | raternal First | | | | | | |
| Sex: M F | DOB: | | Middle | | | | |
| Verified TB: | RVCT: (9 di | or | Not reported | | | | |
| ICE A#: | | OP#: | | | | | |
| Suspected TB Clinical History request (specify year): Immunocompromised (specify): | | | | | | | |
| ² Date of collection | ² Specimen type | ² Smear | Culture | Susceptibility | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Other tests (specify): | | | | | | | |
| ² Imaging | | | | | | | |
| Date | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| E. Medication | | | | | | | |
| For: this referred p | patient Not started Reason for not starte Drug | d: Dose | Start date | Stop date | | | |
| | Diug | Dose | Start date | Stop date | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Expected move date: Patient given days of medication. | | | | | | | |
| Comments: | | | | | | | |
| | | | | | | | |
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| | | | | | | | |
| | | | | | | | |

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