

REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME

Referral / Transfer form for treatment

Serial Number _____

To be filled in triplicate. One copy to be sent to the DTO receiving the patient, one copy to the health facility where the patient is referred to, and one copy to the patient

Name and address of referring health facility _____

Contact Number and e-mail address of referring health facility: _____

Name and address of health facility to which patient is referred _____

Name of patient _____ Age _____ Sex M ☐ F ☐ TG ☐

Complete Address _____

Contact no. _____

Patient detail	
Site of disease <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra Pulmonary, Site _____	Diagnosis details Date of diagnosis: __/__/____ Name of laboratory: _____ Type of test: ZN / FM / CBNAAT / Culture Result : _____ TB notification number: _____
Type of Patient <input type="checkbox"/> New <input type="checkbox"/> Transferred in <input type="checkbox"/> Treatment After Lost to Follow-up	<input type="checkbox"/> Recurrent <input type="checkbox"/> Treatment After Failure <input type="checkbox"/> Others, previously treated (Specify) _____
Case Definition <input type="checkbox"/> Microbiologically confirmed <input type="checkbox"/> Clinically diagnosed	HIV Status: <input type="checkbox"/> R <input type="checkbox"/> NR <input type="checkbox"/> Unknown DST Status: <input type="checkbox"/> Rif Sensitive <input type="checkbox"/> Rif Resistant <input type="checkbox"/> Unknown, if unknown
H/O of ATT: ____ months of treatment ____ months since end of last episode	Sample sent for DST to _____ Date: __/__/____ Treatment regimen: <input type="checkbox"/> New <input type="checkbox"/> Previously Treated Date of treatment initiation: : __/__/____ Number of doses: _____

Referred for:

- ☐ Initiation of treatment
☐ Adverse drug reaction (give details) _____
☐ Transfer out (give details) _____
☐ Any other (give details) _____

Name and designation of the referring doctor _____

Date referred

----- ✂ ----- ✂ -----

Serial Number _____

For use by the health facility where the patient has been referred

Name of receiving health facility _____ Name of TB Unit and District _____

Name of patient _____ TB No (if available) _____

Age _____ Sex M ☐ F ☐ TG ☐ Date of receipt of patient _____

Date of initiation of treatment _____ Treatment regimen _____

Result of End IP specimen examination _____ Date of end IP specimen examination _____

Treatment outcome _____ Date of treatment outcome _____

Signature _____ Designation _____

Date _____

This portion of the form has to be sent back to the referring unit as soon as the patient has been initiated on RNTCP treatment