

RNTCP PMDT Referral for treatment form

(Fill in duplicate. Send one copy to the concerned facility receiving the patient, and file the duplicate)

Name and address of referring unit (District TB Centre/DR TB Centre): _____

E-mail address of referring unit: _____

Name of the facility where patient is referred: _____

Name of patient: _____ Age: _____ Gender: _____

Complete address: _____

<u>Patient detail</u>	
Disease classification: <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra pulmonary (site _____) Type: <input type="checkbox"/> New <input type="checkbox"/> Recurrent <input type="checkbox"/> Treatment after Lost to follow-up <input type="checkbox"/> Treatment after Failure <input type="checkbox"/> Others, previously treated Reason for testing: <input type="checkbox"/> New <input type="checkbox"/> Previously Treated <u><input type="checkbox"/> Presumptive TB</u> <u><input type="checkbox"/> Private referral</u> <u><input type="checkbox"/> Presumptive NTM</u> <u><input type="checkbox"/> Presumptive MDR-TB</u> <input type="checkbox"/> At diagnosis <input type="checkbox"/> Contact of MDR/RR TB <input type="checkbox"/> Follow up Sm +ve <input type="checkbox"/> Private referral <u><input type="checkbox"/> Presumptive H mono/poly</u> <u><input type="checkbox"/> Presumptive XDR-TB</u> <input type="checkbox"/> MDR/RR TB at diagnosis <input type="checkbox"/> ≥ 4 months culture positive <input type="checkbox"/> 3-monthly for persistent culture positives (treatment month _____) <input type="checkbox"/> Culture reversion <input type="checkbox"/> Failure of MDR/RR-TB regimen <input type="checkbox"/> Recurrent case of second line treatment	Latest TB No: _____ Latest regimen: <input type="checkbox"/> Regimen for INH mono/poly resistant TB <input type="checkbox"/> Regimen for MDR/RR TB <input type="checkbox"/> Shorter regimen* <input type="checkbox"/> Modified Regimen for MDR/RR-TB + FQ /SLI resistance <input type="checkbox"/> Regimen for XDR TB <input type="checkbox"/> Modified Regimen for mixed pattern resistance <input type="checkbox"/> Regimen with New Drug for MDR-TB Regimen + FQ/SLI resistance <input type="checkbox"/> Regimen with New Drug for XDR-TB <input type="checkbox"/> Regimen with New Drug for failures of regimen for MDR TB <input type="checkbox"/> Regimen with New Drug for failures of regimen for XDR-TB <input type="checkbox"/> Regimen with New Drug for mixed pattern resistance *whenever available
<u>Sputum, culture and DST details</u> Date of culture result: ____/____/____ Date of DST/LPA/CBNAAT result: ____/____/____ DST/LPA/CBNAAT result* : <input type="checkbox"/> R <input type="checkbox"/> H(inhA) <input type="checkbox"/> H(katG) <input type="checkbox"/> S <input type="checkbox"/> E <input type="checkbox"/> Z <input type="checkbox"/> Km <input type="checkbox"/> Cm <input type="checkbox"/> Am <input type="checkbox"/> Lfx <input type="checkbox"/> Mfx (0.5) <input type="checkbox"/> Mfx (2.0) <input type="checkbox"/> Eto <input type="checkbox"/> PAS <input type="checkbox"/> Lzd <input type="checkbox"/> Cfz <input type="checkbox"/> ____ <input type="checkbox"/> ____ <input type="checkbox"/> ____ (*Tick the drugs to which resistance is demonstrated)	<u>DR TB treatment details</u> PMDT NIKSHAY ID: _____ DR TB Centre: _____ Date of DR TB regimen initiation: : ____/____/____ Number of doses: _____

Date of regimen change and details of change: _____

Past exposure to second-line anti TB drugs: Drugs (duration) _____

HIV Status: ☐ Pos ☐ Neg ☐ Not known Date of CPT initiation: _____ Date of ART initiation: _____

Date of referral to DR-TB Centre / DTC: Day _____ Month _____ Year _____

Referred for:

- ☐ Initiation of treatment
- ☐ Adverse drug reaction (give details) _____
- ☐ Transfer out (give details) _____
- ☐ Ambulatory treatment (if the patient is referred to DTC)
- ☐ Any other (give details) _____

Name and designation of the referring doctor _____

Reminder for the health facility where the patient has been referred

Please send an e-mail to the referring unit, informing the referring doctor of the date that the above-named patient reported at the receiving health facility.