Interjurisdictional TB Notification Cover Sheet

Send with All Referrals/Follow-up

Type of Referral:
- ☐ **Active/Possible TB**
- ☐ **TB Contact**
- ☐ **TB Infection**

→ Call receiving state or local jurisdiction **within 1 business day** and confirm information is received

Online directory of state, big city and territory TB programs: **www.tbcontrollers.org/community/statecityterritory/**

NTCA Recognized Standard for Communication of the IJN Form:

The recommended workflow for the secure transmission of the IJN and additional guidance on completing and sending the IJN Form and Follow-Up is provided in the IJN Companion Guide: **www.tbcontrollers.org/resources/interjurisdictional-transfers/**

Referring
- **Local Jurisdiction**

INITIAL → FOLLOW UP

Name of Local Program: | City: | Date sent to Referring State:

County: | State:

Local Program Contact: | Phone:

☐ Fax: | ☐ Email:

Check box above for preferred document transmission.

Referring
- **State**
- **Big City**
- **Territory**

INITIAL → FOLLOW UP

Name of Program: | Jurisdiction: | Date sent to Receiving State/ Big City/Territory:

Program Contact: | Phone:

☐ Fax: | ☐ Email:

Check box above for preferred document transmission.

Receiving
- **State**
- **Big City**
- **Territory**

INITIAL → FOLLOW UP

Name of Program: | Jurisdiction: | Date sent to Receiving Local:

Program Contact: | Phone:

☐ Fax: | ☐ Email:

Check box above for preferred document transmission.

Receiving
- **Local Jurisdiction**

INITIAL → FOLLOW UP

Name of Local Program: | City:

County: | State:

Local Program Contact: | Phone:

☐ Fax: | ☐ Email:

Check box above for preferred document transmission.

Follow-Up sent to:
- ☐ Receiving State/Big City
- ☐ Referring State/Big City
- ☐ Referring Local

Date Follow-Up sent:

National Tuberculosis Controllers Association (NTCA)
National Tuberculosis Nurse Coalition (NTNC)
Society for Epidemiology in TB Control (SETC)
www.tbcontrollers.org/resources/interjurisdictional-transfers

NOTE: This form contains confidential patient information. Please comply with HIPAA regulations when sending this form. | Rev: 7/2022

Interjurisdictional TB Notification

Active/Evaluation for Possible TB Disease

Referred for: ☐ **TB disease continued care** ☐ **TB disease evaluation**

Call receiving state or local jurisdiction **within 1 business day** and confirm information is received

Date of Expected Arrival:

Client Information

Last Name: | First Name: | Middle Name:

Date of Birth: | Sex at Birth: | Gender Identity: | Race: | Ethnicity:

Country of Birth: | Primary Language: | Interpreter Needed?

New Address: | City:

State/Province/Region: | Zip Code: | County:

Phone 1: | Phone 2: | Email:

Immigrant/Refugee Classification | EDN A# | Transfer Complete in EDN

Alternate Contact Name: | Relationship: | Phone:

Additional Contact Information:

Diagnosis Verified by: | Site of Disease: | Specify extrapulmonary:

If Pulmonary: ☐ Cavitary ☐ Sputum culture conversion documented Date of first negative sputum culture:

Isolation: ☐ Discontinued ☐ Continued isolation necessary, specify:

RVCT (Case Report) Attached (required if counted): ☐ Yes ☐ No

Tests/Results:
Most recent results are attached
(If not attached, please provide reason)

TST/IGRA: | Radiology: | Smear(s): | NAAT:

Culture(s): | Susceptibilities (if culture positive):

Treatment Summary: MAR/DOT Log Attached:

Drug:	Dosage:	Therapy Admin:	Date Started:	Date Stopped:
Drug:	Dosage:	Therapy Admin:	Date Started:	Date Stopped:
Drug:	Dosage:	Therapy Admin:	Date Started:	Date Stopped:
Drug:	Dosage:	Therapy Admin:	Date Started:	Date Stopped:
Drug:	Dosage:	Therapy Admin:	Date Started:	Date Stopped:
Drug:	Dosage:	Therapy Admin:	Date Started:	Date Stopped:

Current Medication Administration Method: ☐ DOT ☐ eDOT ☐ SAT

Side Effects, Adherence, or Administration Problems:

Estimated Treatment Duration: | Last DOT dose administered on:

Date medication given for travel: | # of doses in hand for travel: | Prescription Given:

Comments:

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Interjurisdictional TB Notification Follow-Up

Active/Evaluation for Possible TB Disease

Client Information

Last Name: | First Name: | Date of Birth:

Follow-Up Information

Report Status: | Date of Disposition: | Reason Dispositioned:

If Disposition Other:

Evaluation: | Evaluation Outcome:

Tests/Results:
Most recent results are attached
(If not attached, please provide reason)

TST/IGRA: | Radiology: | Smear(s): | NAAT:

Culture(s): | Susceptibilities (if culture positive):

Treatment Status: | MAR/DOT Log Attached: | If not completed, provide reason:

If Active TB Disease: Counting Jurisdiction: | RVCT#

If Patient Moved: Notified New Jurisdiction:

New Address: | City:

State/Province/Region: | Zip Code: | County:

Phone 1: | Phone 2: | Email:

Comments:

