National TB Control Program (NTP)
Programmatic Management of Drug-resistant Tuberculosis (PMDT)

Form 7. NTP Referral Form

TB Case Number

To: _____ **Date Referred:** _____

Please accommodate the patient bearing this referral form. Kindly inform the Referring DOTS Staff as soon as patient has been evaluated by calling, sending SMS/email or sending back the Return Slip below.

(To be accomplished by Referring Unit)

Name of Referring Unit	**Telephone No.**	**Fax No.**	**E-mail Add.**

Address of Referring Unit

Full Name of Patient (SURNAME, Given Name, Middle Name)	**Age**	**Sex**	**Weight** (kg)

Patient's Address

Reason for Referral:

[ ] For DSSM

[ ] For registration and treatment *(Write regimen below)*

[ ] For continuation of treatment/ transfer-out *(Write regimen below)*

[ ] For IPT (children 0-4 y/o)

[ ] For evaluation of Presumptive DRTB *(Write history below)*

O Relapse
O Treatment After Failure
O Treatment After Lost to Follow-up
O Previous Treatment Outcome Unknown
O HH Contact of DRTB Case
O Non-converter of Cat I or II
O PLHIV with TB symptoms
O Other

[ ] Others, specify _____

Details: History of TB Treatment or Recommended Regimen and Other Pertinent Information

Date Treatment Started-Treatment Unit-Anti-TB Drugs and Duration-Outcome (earliest to latest) or Drug-Preparation-No of Units/Day

Name of Referring DOTS Staff	**Signature**	**Cellphone No./ Email Add.**	**Designation**

Please attach copy of: 1. NTP Treatment Card/s of Previous Treatment/s, 2. Latest DSSM results, 3. Other laboratory results (CXR, TBDC, blood chem.)

Return Slip

Name of Referring Unit: _____

Address of Referring Unit: _____

(To be accomplished by Receiving Unit)

Name of Receiving Unit	**Date Received**	**Contact No.**

Full Address of Receiving Unit

Name of Patient

Name of Receiving DOTS Staff	**Signature**	**Cellphone No./ Email Add.**	**Designation**

Action Taken:

[ ] DSSM performed, write date ____/ ____/ ____ and results _____

[ ] Patient started/ resumed treatment and registered: TB Case No._____ Date Registered/ Resumed ____/ ____/ ____

[ ] Evaluated as Presumptive DR-TB, Xpert test performed write date ____/ ____/ ____ and results _____

[ ] Not enrolled, specify reasons/s _____

[ ] Others, specify _____

Remarks: _____

_____