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.**

Complete Address of Referring Unit

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

Complete Address of Patient	**Contact No. of Patient**

Reason for Referral:

[ ] For DSSM

[ ] For registration and treatment

[ ] For continuation of treatment

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

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

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

[ ] Others, specify _____

REMARKS:

Note: for transfer out, write treatment regimen (e.g. Cat 1 2HRZE/4HR), Registration Group, No. of days on treatment, date treatment started, and other important details)

History of TB Treatment

Date Treatment Started	Name of Treatment Unit	Anti-TB Drugs Taken and Duration	Outcome

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.**

Complete 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 ____/ ____/ ____

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

[ ] Not enrolled, specify reasons/s _____

[ ] Others, specify _____

Remarks: