FORM 7. NTP REFERRAL FORM

TB/ TPT 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 Facility/ Unit	**Telephone No.**	**E-mail Add.**

Address of Referring Facility/ Unit

Patient's Full Name (SURNAME, Given Name, Name Ext., Middle Name)	**Age**	**Sex**	**Weight** (KG)
		[ ] M [ ] F	

Patient's Address [ ] Permanent [ ] Temporary

Reason for Referral:

[ ] For screening

High Risk Clinical Group: ______________

High Risk Population: ______________

Other Risk Factor/s: ______________

[ ] Contact of a confirmed DS/DR-TB Case

[ ] Retreatment

[ ] For start of TPT (Write regimen below)

[ ] For start of TB treatment (Write regimen below)

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

[ ] For continuation of treatment/ decentralize (Write regimen below)

Bacteriological Staus: [ ] BC [ ] CD

Anatomical Site: [ ] P [ ] EP

Drug-susceptibility: [ ] DS [ ] DR [ ] Unk

Treatment History: [ ] New [ ] Retreatment

[ ] 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 laboratory (Xpert and/or Smear) 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

Patient's Full Name

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

Action Taken:

[ ] Lab test ______________ performed, write date ___/ ___/ ___ and results ______________

[ ] Patient started/ resumed treatment: Date Registered/ Resumed ___/ ___/ ___ Regimen: ______________

[ ] Not treated specify reasons/s ______________

[ ] Others, specify ______________

Remarks: ______________

For international referrals:

Patient's Address (Planned Destination)	**Country**

Patient's Contact Number (include country and area code)	**Other Contact Information** (E-mail, Social Media, Instant Messaging)

Contact Person in Destination	**Contact Information of Contact Person** (include country and area code)

PATIENT CONSENT

I, _____, understand that the Department of Health-National TB Control (NTP) is required to collect information regarding my health, treatment, and location for the purpose of proper clinical management. I hereby authorize the NTP to share my information with other health agencies in order to ensure my continuous care. It has been explained to me that all information provided will be treated confidentiality, and may be stored and transmitted in both paper and electronic form.

_____ _____

Patient's Signature over Printed Name

Date: _____

Parent's Signature over Printed Name (if patient is minor)

Date: _____

LABORATORY TEST RESULTS

Date	Test	Results