



CureTB Transnational Notification

Division of Global Migration Health | curetb@cdc.gov
619-385-8019 | www.cdc.gov/cureTB

OMB APPROVED CONTROL
NO 0920-1186
EXP DATE: 5/31/2027



¹Referring Jurisdiction: _____
City County State

¹Contact person: _____¹Telephone: _____ Ext: _____ Fax: _____

Referring Agency: _____ E-Mail Address: _____

☐ Verified TB: ☐ RVCT: _____ – _____ – _____ or ☐ Not reported
Year Reported State (9 digits/letters)

☐ ICE A#: _____ ☐ BOP#: _____ – _____

☐ Suspected TB ☐ Clinical History request (specify year): _____ ☐ Immunocompromised (specify): _____

A. Patient

¹Name: _____
Paternal Maternal
First Middle

Sex: ☐ M ☐ F Alias: _____ DOB: _____

Email 1: _____ Email 2: _____

☐ Check if patient/parent not currently at home. Current location: _____ Telephone: _____

B. Info in U.S.

Address: _____
Street Apt City
County State Zip code Home Phone: _____ Cell: _____

Contact person in the U.S.

Name: _____ Home Phone: _____ Cell: _____
Relationship: _____ Email: _____

C. Destination Country

Address: _____
Street
Apt City County
State Zip code Country

Contact person at destination

Name: _____ Home Phone: _____ Cell: _____
Relationship: _____ Email: _____

D. Clinical Information

Information for: ☐ this referred patient ☐ Other, specify: _____

Site(s) of disease: ☐ Pulmonary ☐ Other(s), specify: _____

☐ HIV ☐ Diabetes ☐ No Symptoms ☐ Symptoms, specify: _____

¹ Fields required to initiate the referral process

² Please send imaging and laboratory reports as attachments

³ Please attach additional information, as needed

⁴ Please contact us via phone to confirm your referral was received

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-1186

¹Name:
Paternal Maternal

First Middle

Sex: ☐ M ☐ F DOB:

☐ Verified TB: ☐ RVCT: – – (9 digits/letters) or ☐ Not reported

☐ ICE A#: ☐ BOP#: –

☐ Suspected TB ☐ Clinical History request (specify year): ☐ Immunocompromised (specify):

² Date of collection	² Specimen type	² Smear	Culture	Susceptibility

Other tests (specify):

²Imaging

Date	² Imaging

E. Medication

For: ☐ this referred patient ☐ Not started Reason for not started:

Drug	Dose	Start date	Stop date

Expected move date: Patient given days of medication.

Comments:

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