



## **CureTB Transnational Notification**

OMB APPROVED CONTROL NO 0920-1186 EXP DATE: 5/31/2024

Division of Global Migration Health | E-mail:  $\underline{curetb@cdc.gov} \ | \ Telephone: 619-542-4013$  Web address:  $\underline{www.cdc.gov/cureTB}$ 

Referring Jurisdiction:	County	State		_ ¹Date sent:
'Contact person:	•	State	Ext:	Fax:
Referring Agency:				
Year Reported State				
ICE A#:	BOP#:			
Suspected TB Clinical History request (specify year):  A. Patient	lmmunoo	compromised (specify):		
<sup>1</sup> Name:			Maternal	
First			Middle	
Sex: M F Alias:				DOB:
Email 1:	Email 2:			
Check if patient/parent not currently at home. Current location:_			Telepl	none:
B. Info in U.S.				
Address:		Apt		City
Jucce		Home Phone:		Cell:
County State  Contact person in the U.S.	Zip code			
Name:		Home Phone:		Cell:
Relationship:		Email:		
C. Destination Country				
Address:				
	Street			
Apt City			County	
Contact person at destination	Zip code		Country	
Name:		Home Phone:		Cell:
Relationship:				
D. Clinical Information				
Information for: this referred patient Other, specify:				
Site(s) of disease: Pulmonary Other(s), specify:				
HIV Diabetes No Symptoms Symptoms, spec				
inv biabetes no symptoms symptoms, spec	y.			

<sup>1</sup> Fields required to initiate the referral process

<sup>2</sup> Please send imaging and laboratory reports as attachments

<sup>3</sup> Please attach additional information, as needed

 $^{\rm 4}$  Please contact us via phone to confirm your referral was received

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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

<sup>1</sup> Name:	Paternal		Maternal				
	raternal First						
Sex: M F	DOB:		Middle				
Verified TB:	RVCT: (9 di	or	Not reported				
ICE A#:		OP#:					
Suspected TB Clinical History request (specify year): Immunocompromised (specify):							
<sup>2</sup> Date of collection	<sup>2</sup> Specimen type	<sup>2</sup> Smear	Culture	Susceptibility			
Other tests (specify):							
<sup>2</sup> Imaging							
Date							
E. Medication							
For: this referred p	patient Not started Reason for not starte Drug	d: Dose	Start date	Stop date			
	Diug	Dose	Start date	Stop date			
Expected move date: Patient given days of medication.							
Comments:							

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