CureTB Transnational Notification

Division of Global Migration and Quarantine | E-mail: curetb@cdc.gov | Telephone: 619-542-4013
Web address: www.cdc.gov/usmexicohealth/curetb.html

OMB APPROVED CONTROL
NO 0920-1186
EXP DATE:2/29/2024

[1]Referring Jurisdiction: ____________ City ____________ County ____________ State [1]Date sent: ____________

[1]Contact person: ____________ [1]Telephone: ____________ Ext: ______ Fax: ____________

Referring Agency: ____________ E-Mail Address: ____________

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

ICE A#: ____________ BOP#: ____________ – ______

Suspected TB Clinical History request (specify year): ______ Immunocompromised (specify): ____________

A. Patient

[1]Name: ____________ 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

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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

[1]Name: ______________________ ______________________
Paternal Maternal

______________________ ______________________
First Middle

Sex: M F DOB: __________

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

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): ______________________

[2]Imaging

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:

[1] Fields required to initiate the referral process
[2] Please send imaging and laboratory reports as attachments
[3] Please attach additional information, as needed