TB 07

NATIONAL TUBERCULOSIS CONTROL PROGRAMME

Directorate General of Health Services, Bangladesh

Tuberculosis Referral/ Transfer Form

(Fill out in triplicate with carbon paper between sheets)

Name of Referring/Tranferring Unit ______________________

Name of Institution to where patient is reffered (If known) : ______________________

Name of Patient : ______________________ Age : ________ Sex : ________

Address (in full) : ______________________

______________________ Phone No.: ________

TB Registration No. : ______________________

Type of Patient:

- ☐ New smear positive
- ☐ New smear negative/EP
- ☐ Re-treatment
- ☐ Others (specify) ________

Type of Treatment:

- ☐ CAT 1
- ☐ CAT 2
- ☐ DR TB
- ☐ Child

Date of treatment started: ______________________

No. of days for which patient received drugs at last attendance ______________________

Reasons for referral : ______________________

Remarks : ______________________

Signature : ______________________

Designation : ______________________

Date Referred/ transferred ______________________

For use by the institution where the patient is referred to send the outcome report to the institution where patient was intially registered

Name of patient : ______________________ TB registration No. : ______________________

Age : ______________________ Sex : M ☐ F ☐

TB Registration no (of the organizationfrom where the patient was referred) : ☐

Treatment result:

Cured ☐ Treatment completed ☐ Failure ☐ Lost to follow up/Defaulted ☐ Died ☐

Date : ________ Date : ________ Date : ________ Date : ________ Date : ________

Signature : ______________________ Name : ______________________

Date : ______________________ Designation : ______________________

Send this part back to the referring unit as soon as the treatment outcome report is available.

For use by institution where patient has been referred

Name of patient : ______________________ TB registration No. : ______________________

Age : ______________________ Sex : M ☐ F ☐

Date Referred/ Transferred : ______________________

Date of Received at this institution on : ______________________

Signature : ______________________

Designation : ______________________

Name of institution from where patient was referred : ______________________

District : ______________________ Date : ______________________

Send this part back to the Referred Unit as soon as patient has reported and been registered and also send the treatment outcome to the center from where the patient was referred after completion of treatment.