

NATIONAL TUBERCULOSIS CONTROL PROGRAMME

Directorate General of Health Services, Bangladesh
Tuberculosis Referral/ Transfer Form

TB 07

(Fill out in triplicate with carbon paper between sheets)

Name of Referring/ Transferring Unit _____

Name of Institution to where patient is referred (If known) : _____

Name of Patient : _____ Age : _____ Sex : _____

Address (in full) : _____

_____ Phone No.: _____

TB Registration No. : _____ e-TB Registration No. : _____

Type of Patient:

Bacteriologically Confirmed		Clinically Diagnosed
Pulmonary	EP Site	Pulmonary Negative <input type="checkbox"/>
Smear positive <input type="checkbox"/>	Smear positive <input type="checkbox"/>	EP <input type="checkbox"/>
X-pert positive <input type="checkbox"/>	X-pert positive <input type="checkbox"/>	Site _____
Culture positive <input type="checkbox"/>	Culture positive <input type="checkbox"/>	

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 : _____

Name & Designation : _____

Organization : _____

Date Referred/ transferred : _____

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

Name of patient : _____ Age : _____ Sex : M F

TB Registration No. : _____ e-TB Registration No. : _____

TB Registration no (of the organization from where the patient was referred) :

Treatment result:

Cured Date : _____ Treatment completed Date : _____ Failure Date : _____

Lost to follow up/ Defaulted Date : _____ Died Date : _____

Signature : _____

Name & Designation : _____

Organization : _____

Date Referred/ transferred : _____

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 : _____ Age : _____ Sex : M F

TB Registration No. : _____ e-TB Registration No. : _____

Date Referred/ Transferred: _____

Date of Received at this institution on : _____

Signature : _____

Name & Designation : _____

Organization : _____

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.