Name: _____

Form 7. NTP REFERRAL FORM

TB CASE NUMBER

To: _____ Date Referred: _____

Please accommodate the patient bearing this referral form. Kindly inform the Referring DOTS Staff as soon as patient has been evaluated by calling, sending SMS/email or sending back the Return Slip below.

(To be accomplished by Referring Unit)

Name of Referring Unit	Telephone No.	Fax No.	E-mail Address

Full Address of Referring Unit

Name of Patient	Age	Sex	Weight (kg)

Patient's Address	Contact Nos.

Reason for Referral:

[ ] For DSSM
[ ] For registration and treatment
[ ] For continuation of treatment
[ ] For IPT (children 0-4 yrs. old)
[ ] For evaluation of Presumptive DRTB
- ○ Relapse
- ○ Treatment after failure
- ○ Tx after lost to follow-up
- ○ Previous tx outcome unknown
- ○ HH Contact of DR-TB case
- ○ Non-converter of Category I or II
- ○ PLHIV with TB symptoms
- ○ Other

[ ] Others, specify _____

History of TB Treatment

Date treatment started	Treatment Unit	Anti-TB drugs taken and duration	Outcome

Printed Name of Referring DOTS Staff	Signature	Cellphone No./ Email add:	Designation

Please attach copy of: 1. NTP Treatment Card/s of Previous Treatment/s, 2. Latest DSSM results, 3. Other laboratory results (CXR, TBDC, blood chem.)

RETURN SLIP

Name of Referring Unit: _____

Address of Referring Unit: _____

(To be accomplished by Receiving Unit)

Name of Receiving Unit	Date Received	Telephone/Fax No.

Full Address of Receiving Unit

Name of Patient

Name of Receiving DOTS Staff	Signature	Cellphone number	Designation

Action/s Taken (check):

[ ] DSSM performed, write date __ /__ /__ and results _____
[ ] patient started/resumed treatment and registered: New TB/IPT Case No. _____date registered__ / __ / __
[ ] evaluated as presumptive DR-TB, Xpert test performed write date __ /__ /__ and results ____
[ ] not enrolled, specify reason/s _____
[ ] others, specify _____
_____

Remarks: _____