RESET

CureTB Binational Notification

Telephone: (619) 542-4013 Fax: (619) 692-8020

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

[1]Contact person: _____ [1]Telephone: (___) _____ Ext. _____ Fax (___) _____

Referring Agency: _____ E-Mail Address: _____

At time of referral the patient was at: _____ Telephone: (____) _____

☐ Verified case: ☐ RVCT#: _____ or ☐ Not reported ☐ ICE A# _____ ☐ BOP# _____
☐ Suspect case ☐ Clinical History request (*specify year*): _____ ☐ Immunocompromised (*specify*): _____

Index Case Information for: ☐ Household Contacts (CN-47H) ☐ Moving Contacts (CN-47M) ☐ Source Case Finding

Patient

[1]Case name: _____ Sex: ☐ M ☐ F
Paternal Maternal First Middle

Alias: _____ DOB: _____

Info. in Mexico / Central America

_____
Number Street Apt City

_____ Telephone: (___) _____
County State Zip code

Contact person in other country: Name: _____ Country: _____

Relationship: _____ Telephone: (____) _____

Info. in U.S.

_____
Number Street Apt City

_____ Telephone: (____) _____
County State Zip code

Contact person in the U.S.: Name: _____ Telephone: (____) _____

Relationship: _____

Clinical Information

Information for: ☐ this referred case ☐ this referred suspect ☐ Index case for contact(s) ☐ Index case for source case investigation

Site (s) of disease: ☐ Pulmonary ☐ Other (s) specify: _____

[2]Date of collection	[2]Specimen type	[2]Smear	Culture	Susceptibility	[2]Chest X-ray	Other tests/results

☐ HIV ☐ Diabetes ☐ No Symptoms ☐ Symptoms specify: _____

Medication

For: ☐ this referred case/suspect ☐ Not started

Drug	Dose	Start date	Stop date

Comments:

Expected move date: _____ to _____

Patient given _____ days of medication.

1. Fields required to initiate the referral process
2. Whenever possible send CXR reports and laboratory reports as attachments to this referral.

PRINT

County of San Diego
Health and Human Service Agency
Public Health Services ▪ TB Control
E-Mail: curetb.hhsa@sdcounty.ca.gov

curetb.org