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| A logo for the european centre for disease prevention and control  AI-generated content may be incorrect. | **International tuberculosis care transfer form** |  |

A person with tuberculosis (TB) disease who has been treated in (*sending country*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is relocating to (*receiving country*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. This form summarises available information about the individual’s personal and clinical data. It also includes contact information for the treating physicians and/or public health authority in the sending country. The data provided is intended solely for use by clinical care providers and should not be further transmitted.

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| 1. **Personal information** | | | | |
| Please indicate if the person with TB agreed to be contacted at the destination:  Yes  No | | | |
| Last name: | | First name: | |
| Date of birth (dd/mm/yyyy): \_\_\_ /\_\_\_ / \_\_\_\_\_ | | Gender:  Male  Female  Other | |
| Nationality: |  | Language(s) spoken: | |
| Phone number: | | E-mail: | |
| **Relocation address:** □ Available (please provide details below). □ Not available | | | |
| Street name, number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ZIP code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City/village: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  District/province: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Contact person at relocation:   * Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Expected transferred date (dd/mm/yyyy): \_\_\_ /\_\_\_ / \_\_\_\_\_ |
| Any additional information about the relocation: | | | |

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| 1. **Description of current TB disease episode** | | |
| **Site(s) of disease**:  Pulmonary  Extrapulmonary  Unknown  For extrapulmonary TB, please specify what organs are affected: | **TB history:**  Date of diagnosis (dd/mm/yyyy): ***\_\_\_ /\_\_\_ / \_\_\_\_\_***  New TB episodePreviously diagnosed/treated  lf previously diagnosed or treated, describe the treatment outcome:  Cured or treatment completed  Treatment failure  Treatment discontinuation  Lost to follow-up  Unknown |
| **Imaging results**:  Most recent imaging test (s) performed:Chest-X-rayCT scanOther (specify): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Most recent imaging results:  Normal findings  Abnormal findings (specify):   |  |  |  | | --- | --- | --- | | Unilateral infiltrates | Unilateral cavity | Pleural effussion | | Bilateral infiltrates | Bilateral cavity | Nodules | | Other (specify): | | | | |
| **Bacteriological confirmation:** Please indicate the most recent results of the laboratory tests performed.   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | *Test* | *Test performed?* | *Date (dd/mm/yyyy)* | *Results* | | | | | Microscopy | yes  no | \_\_\_ /\_\_\_ / \_\_\_\_\_ | positive | negative | pending | unknown | | Culture | yes  no | \_\_\_ /\_\_\_ / \_\_\_\_\_ | positive | negative | pending | unknown | | Genotypic test\* | yes  no | \_\_\_ /\_\_\_ / \_\_\_\_\_ | positive | negative | pending | unknown | | |
| Pathogen identified: ☐ *M. tuberculosis* ☐ *M. africanum* ☐ *M. bovis* ☐ Other species (specify): | |

*\* Any genotypic test used for diagnosis and species identification (with or without drug-susceptibility testing), e.g. polymerase chain reaction (PCR)-based test, automated nucleic acid amplification test (NAAT) or next generation sequencing.*

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| **Drug susceptibility testing:\*\***Please indicate the most recent results of the laboratory tests performed.  Date (dd/mm/yyyy) ***\_\_\_ /\_\_\_ / \_\_\_\_\_***   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | *Drug* | *Susceptible* | *Resistant* | *Pending* | *Unknown* | *Not tested* | | Isoniazid (H) |  |  |  |  |  | | Rifampicin (R) |  |  |  |  |  | | Ethambutol (E) |  |  |  |  |  | | Pyrazinamide (Z) |  |  |  |  |  | | Levofloxacin (Lfx) |  |  |  |  |  | | Moxifloxacin (M) |  |  |  |  |  | | Bedaquiline (B) |  |  |  |  |  | | Linezolid (L) |  |  |  |  |  | | Others (specify): |  |  |  |  |  |   In case of resistance to R and H please provide more information: |

*\*\* Either phenotypic or genotypic test results.*

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| 1. **TB treatment** | |
| **Initial treatment:**  Start date (dd/mm/yyyy): \_\_\_ /\_\_\_ / \_\_\_\_\_  If there is a change at the time of transfer, please provide further information on the current regimen and reason for the change:  The patient was given \_\_\_\_\_\_\_ days of medication for travel.  If medication was provided, please indicate the date (dd/mm/yyyy): \_\_\_ /\_\_\_ / \_\_\_\_\_  Planned end-date of treatment (dd/mm/yyyy): \_\_\_ /\_\_\_ / \_\_\_\_\_ | **Treatment history:**  Treatment adherence: Adequate Poor (specify):  Treatment adverse events:  Yes  No  If yes, please specify:  Treatment interruptions  Yes  No  If yes please provide further information: |
| **Current treatment:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | *Drug (generic name)* | *Formulation (mg/tab)* | *Quantity* | *Frequency* | *Any comment* | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | | |
| Any additional information: | |

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| 1. **Contact details of authority sending the form** | |
| **Sending authority**  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Additional contact** (doctor/health facility/other):  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **This form was completed on [date (dd/mm/yyyy)]:** \_\_\_ /\_\_\_ / \_\_\_\_\_ | |