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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**
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| 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**
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| **Site(s) of disease**: [ ]  Pulmonary [ ]  Extrapulmonary [ ]  UnknownFor extrapulmonary TB, please specify what organs are affected:  | **TB history:**Date of diagnosis (dd/mm/yyyy): ***\_\_\_ /\_\_\_ / \_\_\_\_\_***[ ] New TB episode[ ] Previously diagnosed/treatedlf 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-ray[ ] CT scan[ ] Other (specify): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Most recent imaging results: [ ]  Normal findings [ ]  Abnormal findings (specify):

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| [ ]  Unilateral infiltrates | [ ]  Unilateral cavity | [ ]  Pleural effussion |
| [ ]  Bilateral infiltrates | [ ]  Bilateral cavity | [ ]  Nodules |
| [ ]  Other (specify): |

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| **Bacteriological confirmation:** Please indicate the most recent results of the laboratory tests performed.

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|  *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 |

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| 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) ***\_\_\_ /\_\_\_ / \_\_\_\_\_***

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| *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**
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| **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:**

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| *Drug (generic name)* | *Formulation (mg/tab)* | *Quantity* | *Frequency* | *Any comment* |
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| Any additional information: |

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| 1. **Contact details of authority sending the form**
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| **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)]:** \_\_\_ /\_\_\_ / \_\_\_\_\_ |