International tuberculosis care transfer form

A person with tuberculosis (TB) disease who has been treated in: _____ is relocating to: _____ . This form summarises available information about the individual's personal and clinical data. It also includes contact information of 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.

1. Personal information

Please indicate if the person with TB agreed to be contacted at the destination *of relocation*: ☒ Yes ☐ No

Last name: _____	First name: _____
Date of birth:	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 transfer date:

Any additional information about the relocation:

2. 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: _____

☐ New TB episode ☐ Previously diagnosed/treated

If previously diagnosed or treated, describe the treatment outcome:

Choose an option below:

Imaging results:

Most recent imaging test (s) performed: ☐ Chest-X-ray ☐ CT scan ☐ Other (specify): _____

Most recent imaging results: ☐ Normal findings ☐ Abnormal findings (specifybelow):

Other (Please specify here)

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.*

Drug susceptibility testing:** Please indicate the most recent results of the laboratory tests performed.

Date:_____

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.*

3. TB treatment

Initial treatment:

Start date :_____

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:

_____

Planned end-date of treatment : _____

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:

4. Contact details of sending authority

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]:_____