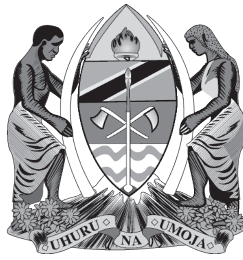
MDR TB 06




Ministry of Health, Community Development,
Gender Eldery and Cildren
National Tuberculosis and Leprosy Programme

# MDR TB
# REFERRAL/TRANSFER FORM

MDR TB 06

**MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER ELDERY AND CHILDREN**
**NATIONAL TUBERCULOSIS AND LEPROSY PROGRAMME**

# MDR TB REFERRAL/TRANSFER FORM

*(Complete top part in triplicate)*

Tick and comment to indicate the reason for this referral or transfer:

☐ Referral to register and begin MDR TB treatment ☐ Referral for ___________ ________________________ ☐ Transfer (registered patient is moving)

Name/address of referring/transferring facility_______________________________________________
District______________________________Region___________________________________________
Name/address of facility to which patient is referred/transferred ________________________________
________________________District_____________________Region___________________________

Name of the Patient (Three Names)________________________________ Age ______

Sex: M ☐ F ☐ Tel/Mobile No:- ___________________________________________________________

Address (if moving, future address) _______________________________________________________

______________________________________________________________________________________

Name and address of contact person for patient_____________________________________________

Mobile No: -

Name and address of Area Leader/Village Secretary ________________________________________

_____________________________________________Mob No: - _____________________________

Diagnosis*________________________________________________________________________

District TB No/MDR TB No: -.* __________________ Date treatment started*____________________

Category of treatment:* -
☐ New cases, smear & culture positive, MDRTB -positive
☐ Retreatment, MDR -TB
☐ New case, smear & culture negative, Extrapulmonary MDR-TB
☐ XDR-TB

**Drug-susceptibility testing (DST) results** (notation method for DST: r = resistant, s = susceptible, c = contaminated). For Xpert MTB/Rif Results, tick on appropriate box

| DST Results Date | INH | RMP | EMB | SM |
|---|---|---|---|---|
| | | | | |

| X-PERT MTB/Rif Results Date | MTB+ Positive | MTB/Rif Positive | MTB Negative | Invalid |
|---|---|---|---|---|
| | | | | |

Drugs patient is receiving by Names ______________________________________________
Remarks (e.g. side-effects observed) ____________________________________________
_____________________________________________________________________________

Name ________________________________________Signature ______________________ Position
_____________ Date of referral/transfer____________________

**Complete if known. If this is a referral for diagnosis, these items may be unknown.*

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**For use by facility to which patient has been referred or transferred:**

Name of facility _______________________________________________________
District ________________________________ Date ________________________

Name of patient ____________________________District TB No/MDR TB No_____________

The above patient reported at this facility on ________________________________________(date)

Name__________________________Signature____________________Position______________

**Send this part back to referring/transferring facility as soon as patient has reported**

NB 1st **Copy: - For the Receiving facility • 2nd Copy: - For the patient • 3rd Copy: - For the Referring facility**