# NATIONAL TUBERCULOSIS CONTROL PROGRAMME

Directorate General of Health Services, Bangladesh

Tuberculosis Referral/ Transfer Form

(Fill out in triplicate with carbon paper between sheets)

Name of Referring/ Transferring Unit _____

Name of Institution to where patient is referred (If known) : _____

Name of Patient: _____ Age: _____ Sex: _____

Address (in full): _____

_____ Phone No.: _____

TB Registration No.: _____ e -TB Registration No.: _____

Type of Patient:

| **Bacteriologically Confirmed** | | **Clinically Diagnosed** |
|---|---|---|
| Pulmonary | EP Site …… | |
| Smear positive ❑ | Smear positive ❑ | Pulmonary Negative ❑ |
| Xpert positive ❑ | Xpert positive ❑ | EP ❑ |
| Culture positive ❑ | Culture positive ❑ | Site |

Type of Treatment:

❑ CAT 1
❑ Retreatment
❑ DR TB
❑ Child

Date of treatment started: _____

No. of days for which patient received drugs at last attendance _____

Reasons for referral: _____

Remarks: _____ Signature: _____

**Name &** Designation: _____

**Organization**: _____

Date Referred/ transferred: _____

For use by the institution where the patient is referred to send the outcome report to the institution where patient was initially registered

Name of patient: _____ Age: _____ Sex: M ❑ F ❑

TB Registration No.: _____ e -TB Registration No.: _____

TB Registration no (of the organizationfrom where the patient was referred): _____

Treatment result:

Cured ❑ Date : _____ Treatment completed ❑ Date : _____ Failure ❑ Date : _____

Lost to follow up/ Defaulted ❑ Date : _____ Died ❑ Date : _____

Signature: _____

**Name &** Designation: _____

**Organization:** _____

Date Referred/ transferred: _____

Send this part back to the referring unit as soon as the treatment outcome report is available.

For use by institution where patient has been referred

Name of patient: _____ Age: _____ Sex: M ❑ F ❑

TB Registration No.: _____ e -TB Registration No.: _____

Date Referred/ Transferred: _____

Date of Received at this institution on : _____

Signature: _____

**Name &** Designation: _____

Organization: _____

Name of institution from where patient was referred: _____

District : _____ Date : _____

Send this part back to the Referred Unit as soon as patient has reported and been registered and also send the treatment outcome to the center from where the patient was referred after completion of treatment.