

# Interjurisdictional TB Notification (IJN) Form

Type of Referral:  Active/Suspect TB - See Section 1

TB Contact - See Section 2

Class A/B - See Section 3

TB Infection - See Section 4

Date of Expected Arrival

Online directory of state and big city TB programs:  
[www.tbcontrollers.org/community/statecityterritory/](http://www.tbcontrollers.org/community/statecityterritory/)

## Referring Jurisdiction Information:

City  County  State   
Person Completing Form  Email   
Phone  Fax

## Form Sent to:

Date IJN Form Sent   
Name  Phone  Fax  Location   
Name  Phone  Fax  Location

## Return Follow-Up Form To:

Follow Up Requested    
Name  Jurisdiction  Location   
Phone  Fax

## Referred Person's Information:

Last Name  First Name  Middle Initial  AKA   
DOB  Sex  Hispanic  Race/Ethnicity   
Country of Birth  Primary Language  Interpreter Needed?

## New Address:

#/St/Apt  City  State  Zip   
Phone 1  Type  Phone 2  Type   
Alternate Contact Name  Phone  Email



National Tuberculosis Nurse Coalition (NTNC)  
National Tuberculosis Controllers Association (NTCA)

[www.tbcontrollers.org/resources/interjurisdictional-transfers](http://www.tbcontrollers.org/resources/interjurisdictional-transfers)

Revision: May 2015



Referred Person's Name

DOB

**SECTION 1: Active/Suspect TB Disease** 

RVCT Number

Site of Disease

Most Recent Respiratory Smear

Treatment Status

Most Recent Respiratory Culture

**Results Attached:** Please attach all applicable results

RVCT  TST/IGRA  Radiology  Smear(s)  NAAT  Culture(s)/Pathology

DST/Mutation Analysis

Submitted for Genotyping

Gentype

**SECTION 2: TB Contact Investigation** 

Date of Last Exposure  Contact Priority  

Initial TB test  Date  Results: attach results  TST mm

8-12 week post exposure  Date  Results: attach results  TST mm

Radiology  Treatment Status

**SECTION 3: Immigrants & Refugees - Class A/B** 

Classification  Alien #  EDN Transfer Complete

TST/IGRA  US Radiology  Sputa

Treatment Status

**SECTION 4: TB Infection - Non-Contact of Class A/B** 

**Results Attached:** TST/IGRA  Radiology  Sputa  Treatment Status

Referred Person's Name

DOB

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### SECTION 5: TB Treatment Summary

**Current** Treatment Summary for:

Drug	<input type="text"/>	Dosage	<input type="text"/>	Therapy Admin	<input type="text"/>	Date Started	<input type="text"/>
Drug	<input type="text"/>	Dosage	<input type="text"/>	Therapy Admin	<input type="text"/>	Date Started	<input type="text"/>
Drug	<input type="text"/>	Dosage	<input type="text"/>	Therapy Admin	<input type="text"/>	Date Started	<input type="text"/>
Drug	<input type="text"/>	Dosage	<input type="text"/>	Therapy Admin	<input type="text"/>	Date Started	<input type="text"/>
Drug	<input type="text"/>	Dosage	<input type="text"/>	Therapy Admin	<input type="text"/>	Date Started	<input type="text"/>
Drug	<input type="text"/>	Dosage	<input type="text"/>	Therapy Admin	<input type="text"/>	Date Started	<input type="text"/>

Estimated Date of Completion  Last DOT dose administered on:  # of doses given for travel

Prescription Given  Side Effects or Adherence Problems  MAR/DOT Log Attached

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**Comments:**

**Note:** This form contains confidential patient information. Please comply with HIPAA regulations when sending this form.