THE UNITED REPUBLIC OF TANZANIA

DR-TB 04

Ministry of Health

National Tuberculosis and Leprosy Programme

DR-TB REFERRAL/TRANSFER FORM

2023 Edition

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(Complete top part in triplicate)

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

☐ Referral to register and begin DR-TB treatment ☐ Referral for _____ _____ ☐ Transfer (registered patient is moving)

Name/address of referring/transferring facility _____

Council _____ Region _____

Name/address of facility to which patient is referred/transferred _____

_____ **Council** _____ 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* _____ **Council** _____

TB No/DR-TB Reg no: _____ Date treatment started* _____

Category of treatment:* -

☐ New cases, smear & culture positive, DR-TB-Positive
☐ Retreatment, DR -TB
☐ New case, smear & culture negative, Extrapulmonary DR-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.*

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

Name of facility _____

Council _____ Date _____

Name of patient _____ **TB No/DR-TB Reg 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