

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/

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

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

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

Comments:

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