Date: [Date]

To: [Receiving Facility/Clinic Name]
Attention: TB Control Program / Infectious Disease Department
Address: [Receiving Facility Address]

SUBJECT: TRANSFER OF CARE FOR ACTIVE TUBERCULOSIS TREATMENT

PATIENT INFORMATION:
Name: [Patient Full Name]
Date of Birth: [DOB]
Gender: [Gender]
Current Address: [Current Address]
Moving to Address: [New Address if known]

DIAGNOSIS & CLINICAL DETAILS:
Diagnosis: [e.g., Pulmonary TB / Extrapulmonary TB]
Site of Disease: [Specify site]
Sputum Smear/Culture Status: [Initial and most recent results]
Drug Sensitivity Testing (DST) Results: [Sensitive to all first-line drugs / Resistance noted]

TREATMENT REGIMEN:
Treatment Start Date: [Date]
Current Medications: [List drugs and dosages]
Dose Frequency: [e.g., Daily DOT / Self-administered]
Total Doses Completed: [Number] of [Total planned doses]
Last Dose Administered: [Date]

CLINICAL PROGRESS:
Adherence History: [Good/Poor/Issues noted]
Side Effects/Complications: [Any reported adverse reactions]
Latest Chest X-ray Date/Result: [Result]

REASON FOR TRANSFER:
[e.g., Patient relocating to your jurisdiction for work/residency]

ATTACHMENTS INCLUDED:
- Diagnostic Radiology Reports
- Laboratory & Culture Results
- Medication Administration Record (MAR)

Please confirm receipt of this patient and the date of their first scheduled appointment at your facility. We have provided the patient with [Number] days of medication for the transition period.

Referring Provider Name: [Name]
Facility Name: [Facility]
Phone Number: [Phone]
Email: [Email]

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Signature