To, Deputy Director Medical Service (TB), Revised National Tuberculosis Control Program, Madurai District

TB Notification Format for Medical Practitioners / Clinics / Hospitals / Nursing Homes

Period of reporting from …… / ……. / ……. To …… / …… / ……

Name of the Health Facility / Practitioner: _________________________________(single / multi)&

Health Establishment code for TB notification

_____________________ / _______________

Registration number: ____________ Telephone with STD: ____________________

Mobile number: _____________________

Complete Address: ____

Sr. No .	Name of TB patient (surname first)	Father / husband name with patient residential ADDRESS, with PIN code	Age in yrs	Sex	GOI issued ID number	Patient phone number	Basis of Diagnosis + & Date of diagnosis	Site of disease (Pulmonary / Extra-Pulmonary)	Patient type * (New / Recurrent / Rx change)	Treatment Started? & If yes, First line / Second line Rx?	Date of Rx initiation & No. of months Rx suggested
							+			Yes / No	dd/mm/yyyy
							dd/mm/yyyy			1st line / 2nd line Rx	number
							+			Yes / No	dd/mm/yyyy
							dd/mm/yyyy			1st line / 2nd line Rx	number
							+			Yes / No	dd/mm/yyyy
							dd/mm/yyyy			1st line / 2nd line Rx	number
							+			Yes / No	dd/mm/yyyy
							dd/mm/yyyy			1st line / 2nd line Rx	number
							+			Yes / No	dd/mm/yyyy
							dd/mm/yyyy			1st line / 2nd line Rx	number

+ Basis of Diagnosis: Sputum microscopy / culture / PCR / LPA / Clinical Examination / X-ray / Others (specify)

***Patient type: New TB case / Recurrent TB case / Treatment change**

& Single – single medical practitioner; multi – more than one medical practitioner

Signature with seal: ___________________________ Date: …… / …… / …….

To, Deputy Director Medical Service (TB), Revised National Tuberculosis Control Program, Madurai District

TB Notification Reporting Format for Laboratory

Period of reporting from …… / ……. / ……. to …… / …… / ……

Name of the Laboratory: ___________________________________ Health Establishment code for TB notification

Registration number: _____________ Telephone with STD: _____________________ ______________________ / ________________

Mobile number: ______________________

Complete Address: ____

Sr. No.	Name of TB patient (surname first) & Name of Referral physician	Father / husband name with patient residential ADDRESS, with PIN code	Age in yrs	Sex	GOI issued ID number	Patient phone number	Type of Test * & Date of test	Test Result & Date of diagnosis	If DST done, DST result for each drug tested (R =resistant; S = sensitive; NA=not available) Rif, INH, SM, EMB, Ofx, Km, Eto, Cipro, Capr, etc							
									Rif	INH	SM	EMB	Ofx	Km	___	___
							(dd/mm/yyyy)	(dd/mm/yyyy)								
							(dd/mm/yyyy)	(dd/mm/yyyy)								
							(dd/mm/yyyy)	(dd/mm/yyyy)								
							(dd/mm/yyyy)	(dd/mm/yyyy)								
							(dd/mm/yyyy)	(dd/mm/yyyy)								

*Sputum smear / X-ray / USG / CT / MRI /solid or liquid culture / molecular test – LPA, Xpert / Aspiration Cytology / Others (specify)

Signature with seal: ____________________________ Date: …… / …… / …….