**Referral Form for Symptomatic TB Contact**

Health district: PHC centre/Hospital TB control Unit:

**Index case**:

Name: Age: Sex: M F

Type of TB: TB registration number:

**Contact:**

Name: Age:

Identification number (from Referral register):

Previous TB treatment: Y N if yes, details:

**Symptoms present (tick all that are present)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Cough |  | Weight loss |  | Chest pain |  |
| Haemoptysis |  | Malnourished |  | Persistent wheeze |  |
| Fever |  | Lethargy |  | Neck swelling |  |
| Night sweats |  | Fatigue |  | Other |  |

**Underlying risk factors for disease (tick all that are present)**

|  |  |
| --- | --- |
| < 5 years of age |  |
| HIV-infected |  |
| Other |  |

**Sputum samples taken from the TB contact:** Y N

If yes, result:

**TB contact referred to** (please, specify the place of referral):

**Date of the referral: Name of community health worker:**