

# Binational Notification

**Telephone: (619) 542-4013**

**Fax: (619) 692-8020**

Card number: \_\_\_\_\_

<sup>1</sup>Referring Jurisdiction: \_\_\_\_\_ <sup>1</sup>Date sent \_\_\_/\_\_\_/\_\_\_

City County State

<sup>1</sup>Contact person: \_\_\_\_\_ <sup>1</sup>Telephone. ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Verified case     RVCT#: \_\_\_\_\_     Not reported     ICE A# \_\_\_\_\_  
 Suspect case     Close contact     Immunocompromised     LTBI     Source case     History request

<sup>1</sup>Patient name: \_\_\_\_\_ Sex  M  F  
Paternal Maternal First Middle

Alias: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

<sup>2</sup>Address in Mexico: \_\_\_\_\_ <sup>2</sup>Telephone: ( ) \_\_\_\_\_  
Number Street Apt Colonia City  
Municipio State Zip code

Address in the U.S.: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
Number Street Apt City  
County State Zip code

<sup>2</sup>Contact person in Mexico: Name: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Relationship: \_\_\_\_\_

<sup>2</sup>Contact person in the U.S.: Name: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Relationship: \_\_\_\_\_

**Clinical information for:**  this referred case/suspect     Index case for this contact     this contact     not applicable

Site (s) of disease:     Pulmonary     Other (s) specify: \_\_\_\_\_

Date of collection	Specimen type	Smear	Culture	Susceptibility	Chest X-ray	Other tests/results

<sup>1</sup>Medication:     this referred case/suspect     this referred contact/LTBI

Drug	Dose	Start date	Stop date

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Expecting moving date to Mexico: \_\_\_/\_\_\_/\_\_\_  
 Patient given \_\_\_\_\_ days of medication

1. - Fields required to initiate the referral process
  2. - At least one address or phone number is essential to establish contact with patient after their departure
  3. When smear negative, please describe Chest X rays results.
- Whenever possible send official CXR reports and laboratory reports as attachments to this referral.

