To: 紹介先 Date:

Respectfully requesting further management of patient bearing this referral form.

Name of Referring Unit: 紹介元の病院名あるいは保健所名

Registration No.

Name of Patient: 患者氏名 Age: Gender: ( )M ( )F

Address: 患者住所

Contact No: 携帯電話番号（本人または家族）

Reason for referral:
(X)For inclusion to DOTS / PMDT of patient based on the findings below:

1. ( )Pulmonary 肺 ( )EP 肺外
2. ( )New 新規 ( )Retreatment 再治療
3. ( )Sm+塗抹陽性 ( )Sm-塗抹陰性
4. CXR 胸部 X 線
   ( )TB, Active 活動性有 ( )TB, Inactive 活動性無 ( )TB Activity Undetermined 活動性不明
5. DST results 薬剤感受性検査結果
   ( )Rif-Susp ( )Rif-Resistant ( )MTB not detected
   ( )Invalid/Error

( )Other reason/s:

Name and Signature of referring official: 医師のお名前と署名をお願いします。

Reply Slip *(Please return to sending unit)*

Registration No.

Date received:

Name of receiving facility:

Address of receiving facility:

Contact No. of receiving facility / officer: /

Name of patient: Age: Gender:

Action taken:

Name, designation and signature of receiving officer:

Date returned: