

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: _____