



National Tuberculosis Controllers Association

Overview of the Updated Interjurisdictional TB Notification (IJN) Form and Companion Guide

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Disclosure

I have NO financial disclosure or conflicts of interest with material discussed in this presentation.



The Updated IJN Form

- Coversheet with distinct referral types on separate pages to facilitate selecting, completing, and sending all and only the information relevant to the referral type(s)
- One referral “packet” can include multiple referral types (ex: 1 active case with 3 household contacts or persons with TB Infection)

Interjurisdictional TB Notification Cover Sheet

Send with All Referrals/Follow-up

- Type of Referral: Active/Possible TB
 TB Contact
 TB Infection



Call receiving state or local jurisdiction **within 1 business day** and confirm information is received

Online directory of state and big city TB programs: www.tbcontrollers.org/community/statecityterritory/

NTNC/NTCA Recognized Standard for Communication of the IJN Form:

The recommended workflow for the secure transmission of the IJN and additional guidance on completing and sending the IJN Form and Follow-Up is provided in the IJN Companion Guide: www.tbcontrollers.org/resources/interjurisdictional-transfers/

Referring • Local Jurisdiction	Name of Local Program: <input type="text"/> City: <input type="text"/> County: <input type="text"/> State: <input type="text"/> Local Program Contact: <input type="text"/> Phone: <input type="text"/> Date sent to Referring State: <input type="text"/> <input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/> <i>Check box above for preferred document transmission.</i>
Referring • State • Big City • Territory	Name of Program: <input type="text"/> Jurisdiction: <input type="text"/> Date sent to Receiving State/Big City/Territory: <input type="text"/> Program Contact: <input type="text"/> Phone: <input type="text"/> <input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/> <i>Check box above for preferred document transmission.</i>
Receiving • State • Big City • Territory	Name of Program: <input type="text"/> Jurisdiction: <input type="text"/> Date sent to Receiving Local Program: <input type="text"/> Program Contact: <input type="text"/> Phone: <input type="text"/> <input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/> <i>Check box above for preferred document transmission.</i>
Receiving • Local Jurisdiction	Name of Local Program: <input type="text"/> City: <input type="text"/> Follow-up: <input type="checkbox"/> County: <input type="text"/> State: <input type="text"/> Local Program Contact: <input type="text"/> Phone: <input type="text"/> <input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/> <i>Check box above for preferred document transmission.</i>

IJN Form



National Tuberculosis Nurse Coalition (NTNC)
 Society for Epidemiology in TB Control (SETC)
 National Tuberculosis Controllers Association

www.tbcontrollers.org/resources/interjurisdictional-transfers/

NOTE: This form contains confidential patient information. Please comply with HIPAA regulations.

Coversheet

Interjurisdictional TB Notification Cover Sheet

Send with All Referrals/Follow-up

Type of Referral: Active/Possible TB →  Call receiving state or local jurisdiction **within 1 business day** and confirm information is received

TB Contact

TB Infection

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INITIAL	FOLLOW UP
Referring • State • Big City • Territory	Name of Program: <input type="text"/> Jurisdiction: <input type="text"/> Date sent to Receiving State/Big City/Territory: <input type="text"/> Program Contact: <input type="text"/> Phone: <input type="text"/> <input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/> <i>Check box above for preferred document transmission.</i>
INITIAL	FOLLOW UP
Receiving • State • Big City • Territory	Name of Program: <input type="text"/> Jurisdiction: <input type="text"/> Date sent to Receiving Local: <input type="text"/> Program Contact: <input type="text"/> Phone: <input type="text"/> <input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/> <i>Check box above for preferred document transmission.</i>
INITIAL	FOLLOW UP
Receiving • Local Jurisdiction	Name of Local Program: <input type="text"/> City: <input type="text"/> Follow-Up sent to: County: <input type="text"/> State: <input type="text"/> <input type="checkbox"/> Receiving State/Big City Local Program Contact: <input type="text"/> Phone: <input type="text"/> <input type="checkbox"/> Referring State/Big City <input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/> Date Follow-Up sent: <input type="text"/> <input type="checkbox"/> Referring Local <i>Check box above for preferred document transmission.</i>



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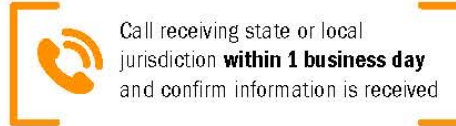
Coversheet

Interjurisdictional TB Notification Cover Sheet

Send with All Referrals/Follow-up

Type of Referral:

- Active/Possible TB
- TB Contact
- TB Infection



Call receiving state or local jurisdiction **within 1 business day** and confirm information is received

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Coversheet

<p>Referring</p> <ul style="list-style-type: none"> • Local Jurisdiction 	<p>Name of Local Program: <input type="text"/> City: <input type="text"/></p> <p>County: <input type="text"/> State: <input type="text"/></p> <p>Local Program Contact: <input type="text"/> Phone: <input type="text"/></p> <p><input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/></p> <p><i>Check box above for preferred document transmission.</i></p> <p>Date sent to Referring State: <input type="text"/></p>
INITIAL	FOLLOW UP
<p>Referring</p> <ul style="list-style-type: none"> • State • Big City • Territory 	<p>Name of Program: <input type="text"/> Jurisdiction: <input type="text"/></p> <p>Program Contact: <input type="text"/> Phone: <input type="text"/></p> <p><input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/></p> <p><i>Check box above for preferred document transmission.</i></p> <p>Date sent to Receiving State/Big City/Territory: <input type="text"/></p>
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INITIAL	FOLLOW UP
<p>Receiving</p> <ul style="list-style-type: none"> • Local Jurisdiction 	<p>Name of Local Program: <input type="text"/> City: <input type="text"/></p> <p>County: <input type="text"/> State: <input type="text"/></p> <p>Local Program Contact: <input type="text"/> Phone: <input type="text"/></p> <p><input type="checkbox"/> Fax: <input type="text"/> <input type="checkbox"/> Email: <input type="text"/></p> <p><i>Check box above for preferred document transmission.</i></p> <p>Follow-Up sent to:</p> <p><input type="checkbox"/> Receiving State/Big City</p> <p><input type="checkbox"/> Referring State/Big City</p> <p><input type="checkbox"/> Referring Local</p> <p>Date Follow-Up sent: <input type="text"/></p>



Active/Evaluation for Possible TB Disease

Interjurisdictional TB Notification

Active/Evaluation for Possible TB Disease PAGE 1 OF 2

Referred for: TB disease continued care Call receiving state or local jurisdiction within 1 business day and confirm information is received TB disease evaluation **Date of Expected Arrival:**

Client Information

Last Name: First Name: Middle Name:

Date of Birth: Sex at Birth: Gender Identity: Race: Ethnicity:

Country of Birth: Primary Language: Interpreter Needed?

New Address: City:

State/Province/Region: Zip Code: County:

Phone 1: Phone 2: Email:

Immigrant/Refugee Classification EDN Af Transfer Complete in EDN

Alternate Contact Name: Relationship: Phone:

Additional Contact Information:

Diagnosis Verified by: Site of Disease: Specify extrapulmonary:

If Pulmonary: Cavitary Sputum culture conversion documented Date of first negative sputum culture:

Isolation: Discontinued Continued isolation necessary, specify:

RVCT (Case Report) Attached (required if counted): Yes No

Tests/Results: ¹ TST/IGRA: Radiology: Smear(s): NAAT:

Most recent results are attached (if not attached, please provide reason) Culture(s): Susceptibilities (if culture positive):

Treatment Summary: MAR/DOT Log Attached:

Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>
Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>
Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>
Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>
Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>
Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>

Current Medication Administration Method: DOT eDOT SAT

Side Effects, Adherence, or Administration Problems:

Estimated Treatment Duration: Last DOT dose administered on:

Date medication given for travel: # of doses in hand for travel: Prescription Given:

Comments:

Interjurisdictional TB Notification Follow-Up

Active/Evaluation for Possible TB Disease PAGE 2 OF 2

Client Information

Last Name: First Name: Date of Birth:

Follow-Up Information

Report Status: Date of Disposition: Reason Dispositioned:

If Disposition Other:

Evaluation: Evaluation Outcome:

Tests/Results: ¹ TST/IGRA: Radiology: Smear(s): NAAT:

Most recent results are attached (if not attached, please provide reason) Culture(s): Susceptibilities (if culture positive):

Treatment Status: MAR/DOT Log Attached: If not completed, provide reason:

If Active TB Disease: Counting Jurisdiction: RVCT#

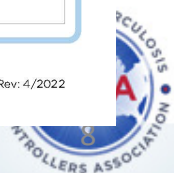
If Patient Moved: Notified New Jurisdiction:

New Address: City:

State/Province/Region: Zip Code: County:

Phone 1: Phone 2: Email:

Comments:



Active/Evaluation for Possible TB Disease

Interjurisdictional TB Notification

Active/Evaluation for Possible TB Disease

PAGE 1 OF 2

Referred for: TB disease continued care
 TB disease evaluation



Call receiving state or local jurisdiction **within 1 business day** and confirm information is received

Date of Expected Arrival:

Client Information

Last Name: First Name: Middle Name:

Date of Birth: Sex at Birth: Gender Identity: Race: Ethnicity:

Country of Birth: Primary Language: Interpreter Needed?

New Address: City:

State/Province/Region: Zip Code: County:

Phone 1: Phone 2: Email:

Immigrant/Refugee Classification EDN A# Transfer Complete in EDN

Alternate Contact Name: Relationship: Phone:

Additional Contact Information:



Active/Evaluation for Possible TB Disease

Diagnosis Verified by: Site of Disease: Specify extrapulmonary:

If Pulmonary: Cavitary Sputum culture conversion documented Date of first negative sputum culture:
 Isolation: Discontinued Continued isolation necessary, specify:

RVCT (Case Report) Attached (required if counted): Yes No

Tests/Results: i TST/IGRA: Radiology: Smear(s): NAAT:
 Most recent results are attached (If not attached, please provide reason) Culture(s): Susceptibilities (if culture positive):

Treatment Summary: MAR/DOT Log Attached:

Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>
Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>
Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>
Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>
Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>
Drug: <input type="text"/>	Dosage: <input type="text"/>	Therapy Admin: <input type="text"/>	Date Started: <input type="text"/>	Date Stopped: <input type="text"/>

Current Medication Administration Method: DOT eDOT SAT
 Side Effects, Adherence, or Administration Problems:
 Estimated Treatment Duration: Last DOT dose administered on:
 Date medication given for travel: # of doses in hand for travel: Prescription Given:

Comments:



Active/Evaluation for Possible TB Disease

Interjurisdictional TB Notification Follow-Up

Active/Evaluation for Possible TB Disease

PAGE 2 OF 2

Client Information


Last Name: First Name: Date of Birth:

Follow-Up Information

Report Status: Date of Disposition: Reason Dispositioned:

If Disposition Other:

Evaluation: Evaluation Outcome:

Tests/Results:  TST/IGRA: Radiology: Smear(s): NAAT:
Most recent results are attached
(if not attached, please provide reason) Culture(s): Susceptibilities (if culture positive):

Treatment Status: MAR/DOT Log Attached: If not completed, provide reason:

If Active TB Disease: Counting Jurisdiction: RVCT#

If Patient Moved: Notified New Jurisdiction:

New Address: City:

State/Province/Region: Zip Code: County:

Phone 1: Phone 2: Email:

Comments:



TB Contact Investigation

Interjurisdictional TB Notification

TB Contact Investigation

Referred for: Location, evaluation Completion of evaluation (evaluation initiated, but the person moved) Date of Expected Arrival:

Client Information

Last Name: First Name: Middle Name:
Date of Birth: Sex at Birth: Gender Identity: Race: Ethnicity:
Country of Birth: Primary Language: Interpreter Needed?
New Address: City:
State/Province/Region: Zip Code: County:
Phone 1: Phone 2: Email:

Alternate Contact Name: Relationship: Phone:

Date of Last Exposure: Contact Priority: Drug Resistant Index Case:

Initial TB Test: Date: Result: TST mm: Report Attached:
8+ week Post-exposure Test: Date: Result: TST mm: Report Attached:

Radiology: Yes No Report Attached:

Treatment Status: MAR/DOT Log Attached:
Starting TB Infection Regimen: Date Started: Estimated Treatment Duration:
Date medication given for travel: # of doses in hand for travel: Prescription Given:
Side Effects, Adherence, or Administration Problems:
Comments:

Follow-Up Information

Report Status: Date of Disposition: Reason Dispositioned:
If Disposition Other:
Evaluation: Evaluation Outcome:

Tests/Results: TST/IGRA: Radiology: Smear(s): NAAT:
Most recent results are attached (if not attached, please provide reason) Culture(s): Susceptibilities (if culture positive):

Treatment Status: MAR/DOT Log Attached: Completing TB Infection Regimen: Date Stopped:

If Patient Moved: Notified New Jurisdiction:
New Address: City:
State/Province/Region: Zip Code: County:
Phone 1: Phone 2: Email:
Comments:

INTERJURISDICTIONAL TB NOTIFICATION (IJN) | www.tbcontrollers.org/resources/interjurisdictional-transfers

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TB Contact Investigation

Interjurisdictional TB Notification

TB Contact Investigation

Date of Expected Arrival:

Referred for: Location, evaluation Completion of evaluation (evaluation initiated, but the person moved)

Client Information

Last Name: First Name: Middle Name:

Date of Birth: Sex at Birth: Gender Identity: Race: Ethnicity:

Country of Birth: Primary Language: Interpreter Needed?

New Address: City:

State/Province/Region: Zip Code: County:

Phone 1: Phone 2: Email:

Alternate Contact Name: Relationship: Phone:

TB Contact Investigation

Date of Last Exposure: <input type="text"/>	Contact Priority: <input type="text"/> ⁱ	Drug Resistant Index Case: <input type="text"/>		
Initial TB Test: <input type="text"/>	Date: <input type="text"/>	Result: <input type="text"/>	TST mm: <input type="text"/>	Report Attached: <input type="text"/>
8+ week Post-exposure Test: <input type="text"/>	Date: <input type="text"/>	Result: <input type="text"/>	TST mm: <input type="text"/>	Report Attached: <input type="text"/>
Radiology: <input type="checkbox"/> Yes <input type="text"/>	<input type="checkbox"/> No <input type="text"/>	Report Attached: <input type="text"/>		
Treatment Status: <input type="text"/>	MAR/DOT Log Attached: <input type="text"/>			
Starting TB Infection Regimen: <input type="text"/>	Date Started: <input type="text"/>	Estimated Treatment Duration: <input type="text"/>		
Date medication given for travel: <input type="text"/>	# of doses in hand for travel: <input type="text"/>	Prescription Given: <input type="text"/>		
Side Effects, Adherence, or Administration Problems: <input type="text"/>				
Comments: <input type="text"/>				

TB Contact Investigation

Follow-Up Information

Report Status: Date of Disposition: Reason Dispositioned:

If Disposition Other:

Evaluation: Evaluation Outcome:

Tests/Results:

Most recent results are attached
(if not attached, please provide reason)

TST/IGRA: Radiology: Smear(s): NAAT:

Culture(s): Susceptibilities (if culture positive):

Treatment Status: MAR/DOT Log Attached: Completing TB Infection Regimen: Date Stopped:

If Patient Moved: Notified New Jurisdiction:

New Address: City:

State/Province/Region: Zip Code: County:

Phone 1: Phone 2: Email:

Comments:

TB Infection Continued Care

Interjurisdictional TB Notification

TB Infection Continued Care (Not a Contact)

Date of Expected Arrival:

Client Information

Last Name: First Name: Middle Name:

Date of Birth: Sex at Birth: Gender Identity: Race: Ethnicity:

Country of Birth: Primary Language: Interpreter Needed?

New Address: City:

State/Province/Region: Zip Code: County:

Phone 1: Phone 2: Email:

Immigrant/Refugee Classification: EDN A#: Transfer Complete in EDN:

Alternate Contact Name: Relationship: Phone:

Additional Contact Information:

Treatment Status:

MAR/DOT Log Attached:

Starting TB Infection Regimen: Date Started: Estimated Treatment Duration:

Date medication given for travel: # of doses in hand for travel: Prescription Given:

Side Effects, Adherence, or Administration Problems:

Tests/Results: ¹ TST/IGRA: Radiology: Smears and Cultures:

Most recent results are attached
(If not attached, please provide reason)

Comments:

Follow-Up Information

Report Status: Date of Disposition: Reason Dispositioned:

Treatment Status: MAR/DOT Log Attached:

Completing TB Infection Regimen: Date Stopped:

If Patient Moved: Notified New Jurisdiction:

New Address: City:

State/Province/Region: Zip Code: County:

Phone 1: Phone 2: Email:

Comments:

INTERJURISDICTIONAL TB NOTIFICATION (IJN) www.tbcontrollers.org/resources/interjurisdictional-transfers

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TB Infection Continued Care

Interjurisdictional TB Notification

TB Infection Continued Care (Not a Contact)

Date of Expected Arrival:

Client Information

Last Name: First Name: Middle Name:

Date of Birth: Sex at Birth: Gender Identity: Race: Ethnicity:

Country of Birth: Primary Language: Interpreter Needed?

New Address: City:

State/Province/Region: Zip Code: County:

Phone 1: Phone 2: Email:

Immigrant/Refugee Classification EDN A# Transfer Complete in EDN

Alternate Contact Name: Relationship: Phone:

Additional Contact Information:



TB Infection Continued Care

Treatment Status:

MAR/DOT Log Attached:

Starting TB Infection Regimen:

Date Started:

Estimated Treatment Duration:

Date medication given for travel:

of doses in hand for travel:

Prescription Given:

Side Effects, Adherence, or Administration Problems:

Tests/Results: 

TST/IGRA:

Radiology:

Smears and Cultures:

Most recent results are attached
(if not attached, please provide reason)

Comments:

TB Infection Continued Care

Follow-Up Information

Report Status: **Date of Disposition:** **Reason Dispositioned:**

Treatment Status: **MAR/DOT Log Attached:**

Completing TB Infection Regimen: **Date Stopped:**

If Patient Moved: Notified New Jurisdiction:

New Address: **City:**

State/Province/Region: **Zip Code:** **County:**

Phone 1: **Phone 2:** **Email:**

Comments:

Interjurisdictional TB Notification

Companion Guide

What is the Interjurisdiction TB Notification (IJN)?

The IJN process is designed to facilitate consistent communication between US reporting areas to ensure continuity of care and timely data sharing.

When should a program use the IJN form?

For persons who need evaluation and/or follow up who moved or live in another jurisdiction than the one where they were initially identified:

- Persons confirmed with or under evaluation for active TB disease (Active/Possible TB)
- Contacts to active TB cases who live outside of or move from the jurisdiction in which the case was reported
- Settings or sites in another jurisdiction where exposure to active TB occurred
- Persons diagnosed with TB infection (also referred to LTBI) initiating or continuing treatment

This form is not appropriate for persons with an immigrant/refugee classification in EDN who have *not initiated* post-immigration medical evaluation before arriving in another jurisdiction.

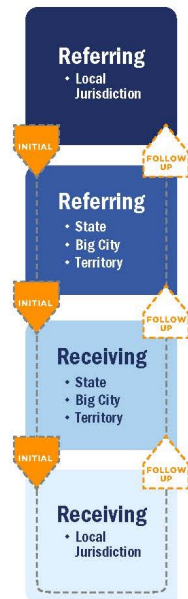
For additional guidance, contact your state TB program.

i Within the form — hover over this symbol for clarification or a link to additional information

Refer to online directory for list of state and big city TB programs:

<http://www.tbcontrollers.org/community/statecityterritory/>

Recommended Workflow



Referring jurisdiction selects applicable pages from four sections

- **Cover Sheet:** one page used for all referrals
- **Active/Possible TB:** two pages summarizing patient status. Attach selected tests and clinical findings as indicated on form
- **Contact:** one page summarizing contact demographic information (or exposure setting information) and details about index case (smear/culture/DST)
 - For follow-up, attach selected tests and clinical findings as indicated on form
- **TB Infection:** one page summarizing person prescribed or started on LTBI treatment

For multiple persons: complete the relevant pages for each person and send **one** cover sheet

If sending via email: ensure email is secure

If sending via fax: ensure entire fax was received

For all referrals for **active/possible TB:** call receiving program **within 1 day** **ensure receipt**

Returning Follow-Up Information

- Complete the follow up section of the page(s) sent by the referring jurisdiction when the evaluation is complete
- **Active/Possible TB:** return within 7 days of referral, at evaluation discontinuation and at treatment stop (if applicable)
- **Contact:** return within 30 days of referral, at evaluation discontinuation and at treatment stop (if applicable)
- **TB Infection:** return within 14 days and at treatment stop
- Return to the preferred route of transmission (fax or email)

IJN Guide

Companion Guide - Process

Interjurisdictional TB Notification

Companion Guide

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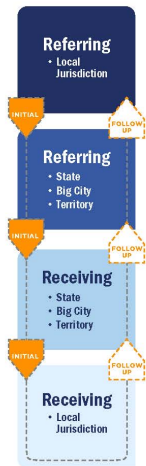
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Recommended Workflow



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If sending via fax: ensure entire fax was received

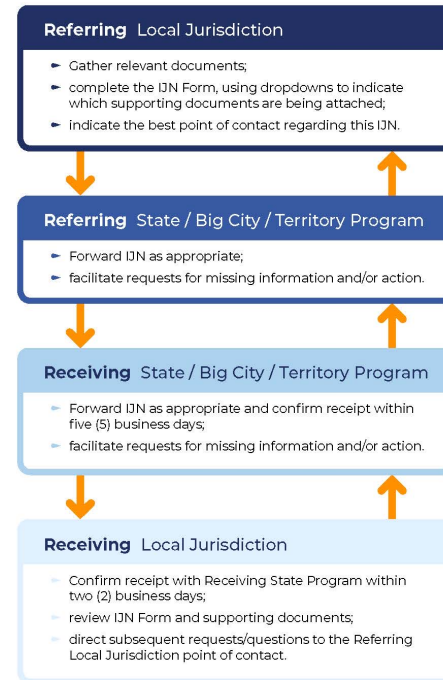
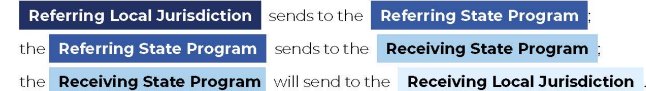
For all referrals for active/possible TB: call receiving program within 1 day to ensure receipt

Returning Follow-Up Information

- Complete the follow up section of the page(s) sent by the referring jurisdiction when the evaluation is complete
- Active/Possible TB:** return within 7 days of referral, at evaluation disposition, and at treatment stop (if applicable)
- Contact:** return within 30 days of referral, at evaluation disposition, and/or treatment stop (if applicable)
- TB Infection:** return within 14 days and at treatment stop
- Return to the preferred route of transmission (fax or email)

NTNC/NTCA Recognized Standard for Communication of the IJN Form:

Initial and Follow-up IJN Forms should consistently follow communication via the recognized standard workflow order:



Companion Guide - Glossary

Glossary of Drop-Down Selections

8+ week Post-exposure Test	TST, QFT, T-Spot, Needs Testing, N/A, Other
Completing TB Infection Regimen	3HP, RIF (4 months), INH (9 months), INH (6 months), 3HR, 2RIPE, Other
Contact Priority	High, Medium/close, Low/other-than-close
Cultures(s)	Yes, No; Pending, No; Not Done
Diagnosis Verified By	Culture, NAA, Smear/Tissue, Clinical Case, Provider Diagnosis, Pending
Drug	Isoniazid, Rifampin, Pyrazinamide, Ethambutol, Rifabutin, Rifapentine, Ethionamide, Streptomycin, Amikacin, Kanamycin, Capreomycin, Ciprofloxacin, Levofloxacin, Ofloxacin, Moxifloxacin, Cycloserine, PAS, Bedaquiline, Linezolid, Delamanid, Clofazimine, Pretomanid, Other
Drug Resistant Index Case	Yes, No, Pending
Ethnicity	Not Hispanic, Hispanic
Evaluation	Initiated, Completed, Not Done, Referred, N/A
Evaluation Outcome	No Infection/Disease, TB Infection, Active Disease, Pending, N/A
Gender Identity	Female, Male, Transgender man, Transgender woman, Genderqueer/gender nonconforming, other (specify in comments), Decline to answer
If not completed, provide reason <i>(Active/Evaluation for TB)</i>	Adverse Effect of Medicine, Client Chose to Stop, Lost to Follow-Up, Moved, Death, Provider Decision, Other
Immigrant/Refugee Classification	A, B0, B1, B2, B3
Initial TB Test	TST, QFT, T-Spot, Needs Testing, N/A, Other
Interpreter Needed	Yes, No
MAR/DOT Log Attached	Yes, No
NAAT	Yes, No; Pending, No; Not Done
Notified New Jurisdiction	Yes, No
Prescription Given	Yes, No
Race	American Indian, Alaska Native, Asian, Black or African American, Native Hawaiian/Pacific Islander, White, Unknown
Radiology	Yes, No; Pending, No; Not Done
Radiology: No	Not Done, Unknown, N/A
Radiology: Yes	Consistent with TB, Not Consistent with TB

Glossary of Drop-Down Selections *cont'd*

Reason Dispositioned <i>(Active/Evaluation for TB and Contact)</i>	Follow-Up Completed, Declined Evaluation, Never Located, Lost to Follow-Up, Moved, Died, Other
Reason Dispositioned <i>(TB Infection)</i>	Follow-Up Completed, Declined Evaluation, Not TB Infection, Never Located, Lost to Follow-Up, Moved, Died
Report Attached	Yes, No
Report Status	Preliminary, Final
Result	Positive, Negative, Indeterminate, Borderline
RVCT Attached: No	Not counted by referring jurisdiction, Burden Case, Contact State TB Program for RVCT
Sex at Birth	F, M
Site of Disease	Pulmonary, Extrapulmonary, Pulmonary and extrapulmonary
Smear(s)	Yes, No; Pending, No; Not Done
Smears and Cultures	Yes, No; Pending, No; Not Done
Starting TB Infection Regimen	3HP, RIF (4 months), INH (9 months), INH (6 months), 3HR, 2RIPE, Other
Susceptibilities <i>(if culture positive)</i>	Yes, No; Pending, No; Not Done
Therapy Admin	Daily DOT, Daily SAT, 5x wk DOT, 5x wk SAT, 3x wk DOT, 3x wk SAT, 2x wk DOT, 2x wk SAT, 1x wk DOT, 1x wk SAT, Other: see MAR
Transfer Complete in EDN	Yes, No
Treatment Status <i>(Active/Evaluation for TB)</i>	Completed, Continuing, Started, Not Completed, Referred, N/A
Treatment Status <i>(Contact Referral)</i>	Treatment Started, Needs Treatment, Window Prophylaxis Started, Needs Window Prophylaxis, Unknown/Needs Evaluation
Treatment Status <i>(Contact and TB Infection Follow-Up)</i>	Completed, Continuing, Started, Not Started, Referred, Stopped: Adverse Effect, Stopped: Client Decision, Stopped: Provider Decision, Stopped: Lost to follow-up, Stopped: Died, N/A
Treatment Status <i>(TB Infection Referral)</i>	Treatment Started, Needs Treatment
TST/IGRA	Yes, No; Pending, No; Not Done



Companion Guide

What is the Interjurisdiction TB Notification (IJN)?

The IJN process is designed to facilitate consistent communication between US reporting areas to ensure continuity of care and timely data sharing.

When should a program use the IJN form?

For persons who need evaluation and/or follow up who moved or live in another jurisdiction than the one where they were initially identified:

- ▶ Persons confirmed with or under evaluation for active TB disease (Active/Possible TB)
- ▶ Contacts to active TB cases who live outside of or move from the jurisdiction in which the case was reported
- ▶ Settings or sites in another jurisdiction where exposure to active TB occurred
- ▶ Persons diagnosed with TB infection (also referred to LTBI) initiating or continuing treatment

This form is not appropriate for persons with an immigrant/refugee classification in EDN who have *not initiated* post-immigration medical evaluation before arriving in another jurisdiction.

For additional guidance, contact your state TB program.

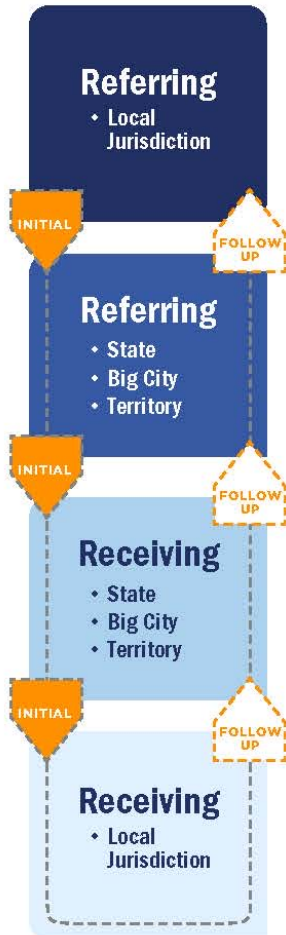
 Within the form — hover over this symbol for clarification or a link to additional information

Refer to online directory for list of state and big city TB programs:

<http://www.tbcontrollers.org/community/statecityterritory/>

Companion Guide

Recommended Workflow



Referring jurisdiction selects applicable pages from four sections

- ▶ **Cover Sheet:** one page used for all referrals
- ▶ **Active/Possible TB:** two pages summarizing patient status. Attach selected tests and clinical findings as indicated on form
- ▶ **Contact:** one page summarizing contact demographic information (or exposure setting information) and details about index case (smear/culture/DST).
 - ▶ For follow-up, attach selected tests and clinical findings as indicated on form
- ▶ **TB Infection:** one page summarizing person prescribed or started on LTBI treatment

For multiple persons: complete the relevant pages for each person and send with one cover sheet

If sending via email: ensure email is secure

If sending via fax: ensure entire fax was received

For all referrals for **active/possible TB:** call receiving program **within 1 day to ensure receipt**

Returning Follow-Up Information

- ▶ Complete the follow up section of the page(s) sent by the referring jurisdiction when the evaluation is complete
- ▶ **Active/Possible TB:** return within 7 days of referral, at evaluation disposition, and at treatment stop (if applicable)
- ▶ **Contact:** return within 30 days of referral, at evaluation disposition, and/or treatment stop (if applicable)
- ▶ **TB Infection:** return within 14 days and at treatment stop
- ▶ Return to the preferred route of transmission (fax or email)

Companion Guide

NTNC/NTCA Recognized Standard for Communication of the IJN Form:

Initial and Follow-up IJN Forms should consistently follow communication via the recognized standard workflow order:

Referring Local Jurisdiction sends to the **Referring State Program** ;
the **Referring State Program** sends to the **Receiving State Program** ;
the **Receiving State Program** will send to the **Receiving Local Jurisdiction** .



Companion Guide

Glossary of Drop-Down Selections

8+ week Post-exposure Test	TST, QFT, T-Spot, Needs Testing, N/A, Other
Completing TB Infection Regimen	3HP, RIF (4 months), INH (9 months), INH (6 months), 3HR, 2RIPE, Other
Contact Priority	High, Medium/close, Low/other-than-close
Cultures(s)	Yes, No: Pending, No: Not Done
Diagnosis Verified By	Culture, NAA, Smear/Tissue, Clinical Case, Provider Diagnosis, Pending
Drug	Isoniazid, Rifampin, Pyrazinamide, Ethambutol, Rifabutin, Rifapentine, Ethionamide, Streptomycin, Amikacin, Kanamycin, Capreomycin, Ciprofloxacin, Levofloxacin, Ofloxacin, Moxifloxacin, Cycloserine, PAS, Bedaquiline, Linezolid, Delamanid, Clofazimine, Pretomanid, Other
Drug Resistant Index Case	Yes, No, Pending
Ethnicity	Not Hispanic, Hispanic
Evaluation	Initiated, Completed, Not Done, Referred, N/A
Evaluation Outcome	No Infection/Disease, TB Infection, Active Disease, Pending, N/A
Gender Identity	Female, Male, Transgender man, Transgender woman, Genderqueer/gender nonconforming, other (specify in comments), Decline to answer
If not completed, provide reason <i>(Active/Evaluation for TB)</i>	Adverse Effect of Medicine, Client Chose to Stop, Lost to Follow-Up, Moved, Death, Provider Decision, Other
Immigrant/Refugee Classification	A, B0, B1, B2, B3
Initial TB Test	TST, QFT, T-Spot, Needs Testing, N/A, Other
Interpreter Needed	Yes, No
MAR/DOT Log Attached	Yes, No
NAAT	Yes, No: Pending, No: Not Done
Notified New Jurisdiction	Yes, No
Prescription Given	Yes, No
Race	American Indian, Alaska Native, Asian, Black or African American, Native Hawaiian/Pacific Islander, White, Unknown
Radiology	Yes, No: Pending, No: Not Done
Radiology: No	Not Done, Unknown, N/A
Radiology: Yes	Consistent with TB, Not Consistent with TB

Glossary of Drop-Down Selections *cont'd*

Reason Dispositioned <i>(Active/Evaluation for TB and Contact)</i>	Follow-Up Completed, Declined Evaluation, Never Located, Lost to Follow-Up, Moved, Died, Other
Reason Dispositioned <i>(TB Infection)</i>	Follow-Up Completed, Declined Evaluation, Not TB Infection, Never Located, Lost to Follow-Up, Moved, Died
Report Attached	Yes, No
Report Status	Preliminary, Final
Result	Positive, Negative, Indeterminate, Borderline
RVCT Attached: No	Not counted by referring jurisdiction, Burden Case, Contact State TB Program for RVCT
Sex at Birth	F, M
Site of Disease	Pulmonary, Extrapulmonary, Pulmonary and extrapulmonary
Smear(s)	Yes, No: Pending, No: Not Done
Smears and Cultures	Yes, No: Pending, No: Not Done
Starting TB Infection Regimen	3HP, RIF (4 months), INH (9 months), INH (6 months), 3HR, 2RIPE, Other
Susceptibilities <i>(if culture positive)</i>	Yes, No: Pending, No: Not Done
Therapy Admin	Daily DOT, Daily SAT, 5x wk DOT, 5x wk SAT, 3x wk DOT, 3x wk SAT, 2x wk DOT, 2x wk SAT, 1x wk DOT, 1x wk SAT, Other: see MAR
Transfer Complete in EDN	Yes, No
Treatment Status <i>(Active/Evaluation for TB)</i>	Completed, Continuing, Started, Not Completed, Referred, N/A
Treatment Status <i>(Contact Referral)</i>	Treatment Started, Needs Treatment, Window Prophylaxis Started, Needs Window Prophylaxis, Unknown/Needs Evaluation
Treatment Status <i>(Contact and TB Infection Follow-Up)</i>	Completed, Continuing, Started, Not Started, Referred, Stopped: Adverse Effect, Stopped: Client Decision, Stopped: Provider Decision, Stopped: Lost to follow-up, Stopped: Died, N/A
Treatment Status <i>(TB Infection Referral)</i>	Treatment Started, Needs Treatment
TST/IGRA	Yes, No: Pending, No: Not Done

Thank you Workgroup Members!

Ann Sittig – Minnesota

Antoine Perrymon – Georgia

Ben Katz – Tennessee

Danielle Orcutt – Connecticut

Diana Fortune – NTCA

Haley Blake – Las Vegas, NV

Heidi Behm – Oregon

India Solomon – North Carolina

Jenni Wheeler – North Carolina

Jenna Maturino – Arkansas

Karla Jenkins – Utah

Kathryn Yoo – Louisiana

Kimberly Townsend – Montgomery, MD

Laura Young – Virginia

Lori Johnston – Florida

Lisa Paulos – Maryland

Maria Lasley – Kentucky

Maureen Murphy-Weiss – Columbus, OH

Mia Rosario – Florida

Nadya Sabuwala – Minnesota

Noelene Jones – New York City, NY

Rose Young – Texas

Shona Smith – Michigan

Susan McElhany – Nevada





National Tuberculosis Controllers Association

What is an IJN?

The Interjurisdictional TB Notification (IJN) process is designed to facilitate consistent communication between US reporting areas to ensure continuity of care, contact investigations, and timely data sharing

Why the Form Update?

- Existing IJN form and follow-up form were last revised in 2015
- DTBE implemented additional variables to be collected on contacts
- Other potentially useful fields could be added
- Other fields possibly outdated, had error, or could be reworked

Who Made the Updates?

- Workgroup formed with representation from
 - NTNC (National TB Nurses Coalition)
 - SETC (Society for Epidemiology in TB Control)
 - NTCA's IJN Coordinator List (program contacts listed on the NTCA webpage)
- Co-Chairs
 - NTNC sitting President Maureen Murphy-Weiss
 - SETC sitting President Shona Smith
- NTCA Support
 - Diana Fortune



Process and Timing

