LINE-LIST OF PERSONS REFERRED FROM ICTC TO RNTCP

REPORTING MONTH: YEAR NAME OF ICTC: NAME OF DISTRICT:

TO BE COMPLETED BY ICTC COUNSELLOR							***TO BE COMPLETED BY the STS***					
1	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***	***11***	***12***	***13***
Sr. No.	***PID NO.***	***Complete Name & Complete Address***	***Age***	***Sex***	***Date of referral to RNTCP***	***Name of facility referred to***	***Is patient diagnosed as TB – Yes or No***	***If diagnosed as TB, specify whether patient is S+ TB, S- TB or EP TB***	***Is patient initiated on DOTS – Yes or No***	***Date of Starting Treatment***	***TB No.***	***Remarks***

Sign of Counsellor *Sign of MO- ICTC*
Date of completion:

Name of the TU:
Signature of STS : *Signature of DTO/CTO/MO-TU*
Date of Completion: