Table 1: LINE-LIST OF PERSONS REFERRED FROM ART CENTRE TO RNTCP

NAME OF ART CENTRE: _____ NAME OF DISTRICT:_____ MONTH/YEAR:_____

To be completed by ART/CCC Nurse										To be completed by STS				
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*1.*
Sr. No.	Pre-ART/ART Number	Complete Name & Complete Address	Age	Sex	Date of referral to RNTCP for investigation	Name of facility referred to	Is patient diagnosed as TB (Yes/No)	If TB, specify Sputum-Positive Sputum-Negative , or Extra-Pulm TB	Date of referral to RNTCP for treatment	Date of Starting TB Treatment	TB Number with TU Name	Is the patient referred outside district (Yes/No)	Initiated on Non-RNTCP treatment (Yes/No)	
Sign of ART Nurse Date of completion						Sign of SMO/MO-ART				Sign of STS Sign of DTO Date of completion				