TB NOTIFICATION

(Monthly Report)

Period of reporting From...../...../.....To ...../...../.....

Name of the Health Facility/Practitioner/Laboratory:_____

Registration Number:_____Telephone Number(with STD):_____

Complete Address:_____

Sl. No	Name of the Patient/ID of the Patient	Age (Years)	Sex (M/F/O)	GOI issued identification number(Aadhaar etc) ,if available	Complete residential address	Patient phone number	Date of TB Diagnosis	Date of treatment initiation

Signature :..... Date:...../...../.....