

Initial Report on Patient with Tuberculosis (TB)

Physician _____ Date _____
 Address _____ Patient's Name _____
 _____ Address _____
 Telephone _____ DOB _____ Telephone _____

The above identified patient suspected/diagnosed as having tuberculosis has given your name as his/her attending physician. Since tuberculosis is a communicable disease, the County Public Health Department is required by law to assure that every tuberculosis patient receives proper treatment, follow-up supervision and contact investigation. In order to comply with Georgia Statutes and to assure quality care for this patient, your cooperation in completing, signing and returning this form is necessary. This form is due to the County Public Health Department by _____.

NEW TB CASE? YES _____ NO _____ OLD CASE REACTIVATED? YES _____ NO _____

TUBERCULOSIS STATUS

SKIN TEST RESULTS
 Date _____
 Not Done _____
 Mantoux _____ mm
 Tine _____ mm

X-RAY FINDINGS
 Date _____
 Normal _____
 Abnormal _____
 Cavitory _____
 Noncavitory _____
 Stable _____
 Worsening _____
 Improving _____

BACTERIOLOGICAL STATUS
 Date _____
 Type of Specimen _____
 Smear: Pos _____ Neg _____ Not Done _____
 Culture: Pos _____ Neg _____ Nor Done _____
 Pending _____
 If positive please specify:
M. tuberculosis _____
 Other mycobacteria _____

<u>LOCATION OF DISEASE</u>	<u>CLINICAL/LAB RESULTS</u>	<u>CHEMOTHERAPY STATUS</u>	<u>Date</u>	<u>#Doses Given</u>
Pulmonary _____	Date _____	<u>Medication</u>	<u>Started</u>	<u>To Date</u>
Pleural _____	AST/SGOT _____	Isoniazid _____ mg PO	_____ X wk	_____
Lymphatic _____	Date _____	Rifampin _____ mg PO	_____ X wk	_____
Bone or Joint _____	Visual Acuity _____	Ethambutol _____ mg PO	_____ X wk	_____
Genitourinary _____	Color Discrimination _____	Pyrazinamide _____ mg PO	_____ X wk	_____
Miliary _____	Date _____	Pyridoxidine _____ mg	_____ X wk	_____
Meningeal _____	Hearing _____	_____ mg	_____ X wk	_____
Peritoneal _____		None _____	Reason _____	
Other (Specify) _____				

CONTACT FOLLOW-UP
 I have already tested the contacts of the above named patient and will complete and return the enclosed contact form. _____
 I prefer that the County Public Health Department provide contact investigation and follow-up. _____

MEDICAL CARE
 "Treatment of tuberculosis benefits both the community as a whole and the individual patient; thus, any public health program or private provider (or both in a defined arrangement by which management is shared) undertaking to treat a patient with tuberculosis is assuming a public health function that includes not only prescribing an appropriate regimen but also ensuring adherence to the regimen until treatment is completed (ATS/CDC/IDSA: Treatment of Tuberculosis, 2003)." Please indicate who will provide the following (PMD = Private Medical Provider / HD = Health Department):

PATIENT CARE	PMD _____ HD _____	CHEST X-RAY	PMD _____ HD _____
TB MEDICATION*	PMD _____ HD _____	AST/SGOT	PMD _____ HD _____
SPUTUM EXAMINATION	PMD _____ HD _____	HEARING	PMD _____ HD _____
OTHER SPECIMEN (Specify)	PMD _____ HD _____	VISUAL ACUITY/COLOR	PMD _____ HD _____
BLOOD WORK (Specify)	PMD _____ HD _____		
DIRECTLY OBSERVED THERAPY**	PMD _____ HD _____		

Date of patient's next appointment with you: _____

*If the Health Department provides TB Medications to the client, a monthly assessment MUST be done by the Health Department provider.
 **PLEASE NOTE: Directly Observed Therapy is the standard of care for all patients suspected/diagnosed as having TB in Georgia.

In the event you prefer to provide the above services yourself, a follow-up form will be sent to you every month to obtain patient status and contact data. In this manner, the County Public Health Department will fulfill its obligation in assuring that this patient and his/her contacts are receiving adequate care. Be assured that all information provided will be held in confidence and used for official purposes only.

Physician's signature _____ Date _____

Please address your response: Attention: _____ M.D./P.H.N.
 Address _____