

Follow-up Report on Patient with Tuberculosis (TB)

Physician _____
 Address _____
 Telephone _____

Date _____
 Patient _____
 Address _____
 DOB _____ Telephone _____

"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)."

Since tuberculosis is a communicable disease, the County Public Health Department is required by law to assure that every tuberculosis patient receives proper treatment and follow-up. Please provide us with the most recent information available on the above identified patient. To keep medication orders accurate, please list and date current medication order, any dosage changes, or when medications have been discontinued as listed below. In order to comply with Georgia Statues your cooperation is necessary in completing, signing and returning this form to the County Public Health Department by _____.

X-RAY FINDINGS:

Date _____
 Normal _____
 Abnormal _____
 Cavitary _____
 Non Cavitary _____
 Stable _____
 Worsening _____
 Improving _____

BACTERIOLOGIC STATUS:

Date _____
 Type of Specimen _____
 Smear: Pos _____ Neg _____ Not Done _____
 Culture: Pos _____ Neg _____ Not Done _____
 Culture Pending _____
 Last Negative (Date) _____ # of Negative Cultures Since Last Positive _____
 Last Positive (Date) _____
 If positive please specify:
 M. Tuberculosis _____ Other Mycobacteria _____
 Drug Susceptibilities Ordered? Yes _____ (Attach Copies) No _____

CLINIC/LAB RESULTS:

	Date	Results		Date	Results
AST/SGOT	_____	_____	Vision	_____	_____
Hearing	_____	_____	Color	_____	_____
_____	_____	_____	_____	_____	_____

CURRENT CHEMOTHERAPY STATUS: Date _____

Medication			Date Started	Discontinued	Reason	Total # Doses Given to Date
Isoniazid	_____ mg PO	___ X wk	_____	_____	_____	_____
Rifampin	_____ mg PO	___ X wk	_____	_____	_____	_____
Ethambutol	_____ mg PO	___ X wk	_____	_____	_____	_____
Pyrazinamide	_____ mg PO	___ X wk	_____	_____	_____	_____
Pyridoxine	_____ mg	___ X wk	_____	_____	_____	_____
_____	_____ mg	___ X wk	_____	_____	_____	_____
_____	_____ mg	___ X wk	_____	_____	_____	_____

Name of Person doing Directly Observed Therapy _____ or DOT sheet is attached _____

COMMENTS: (Please use reverse side of page if necessary.)

Physician's Name _____ Date _____

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