

Date: _____ County: _____

Client Initials _____ DOB: _____ Computer #: _____ State Case #: _____

| Criteria | Met | Not Met | N/A | Comments |
|--|-----|---------|-----|----------|
| Reporting and Notification | | | | |
| Notification date documented | | | | |
| Initial Report (form 3140 or 3141) and/or discharge summary from hospital | | | | |
| Monthly Follow up Reports from PMD (form 3142) if co-managed | | | | |
| Interjurisdictional TB Notification (NTCA 5-2015) | | | | |
| TB Classification within 90 days | | | | |
| Initial RVCT form completed within 7 days (Send to District TB) | | | | |
| Follow Up RVCT form completed and sent to District TB within 2 months of RVCT (Follow Up Report – 1) | | | | |
| Follow Up RVCT form completed and sent to District TB (Follow Up Report – 2) | | | | |
| Legal | | | | |
| Discount Eligibility Form on file | | | | |
| Signed Consent (form 3609) | | | | |
| Signed Treatment Plan (form 3144) | | | | |
| Signed DOT agreement for TB Treatment (form 603 DOT) | | | | |
| Signed DOT Provider Agreement (form 604 DOT) | | | | |
| Signed VDOT Agreement for TB treatment (Form 603.VDOT.TB) | | | | |
| Signed Release of Information | | | | |
| Documentation of Patient receiving Medication Information Sheet (DPH04/328HW) | | | | |
| Signed Consent for Non-Childproof Containers or Medication Containers | | | | |
| Case Management | | | | |
| TB Services (form 3121) Documented date sent to Pharmacy | | | | |
| Read note for the record to ensure following M.D. orders | | | | |
| Physical Assessment in chart (hospital, physician or HD) | | | | |
| Initial chest x-ray report in chart & EMR | | | | |
| Follow up Chest x-ray reports in chart & EMR | | | | |
| HIV status or testing using opt out and post test counseling documented | | | | |
| Baseline labs: Liver Function Test, CBC with platelet count, serum creatinine, HgbA1C, Hepatitis C for all adults, B profile, if indicated and a pregnancy test. | | | | |
| Other labs ordered per history and protocol | | | | |
| Baseline visual acuity testing and red/green color discrimination for clients on Ethambutol. | | | | |
| Appropriate client education documented: Utilizing Client Education/Counseling Guidelines in P&P | | | | |
| 3 Consecutive diagnostic sputum specimens collected | | | | |
| 3 Consecutive negative sputum smears date documented | | | | |
| Monthly sputum specimen obtained, unable to obtain or induction documented | | | | |
| 2 months sputum status documented | | | | |
| Initial TB Drug Susceptibility | | | | |
| Medication order correct in EMR | | | | |
| Started on appropriate medications with at least 4 Drugs | | | | |
| Medication start date documented in chart and EMR | | | | |
| Appropriate number of doses within time frame | | | | |
| DOT form complete and current (form 3130) | | | | |
| Appropriate action documented for side effects, adverse reactions and other identified problems | | | | |
| Monthly labs: Liver Function Test & CBC with platelets, serum creatinine if clinical indicated in chart & EMR | | | | |
| Allergies addressed in chart & EMR | | | | |
| Problem list utilized in chart | | | | |
| Chart order correct | | | | |

