DPH Georgia Department of Public Health — TB PREVENTION AND CONTROL

Tuberculosis Services

#3121-R (Rev. 01/2020)

❑ Suspect ❑ Case ❑ LTBI ❑ Presumptive LTBI ❑ B1/B2 Refugee or Immigrant ❑ MDR ❑Ryan White ❑ Child less than 5 years

Private Physician or Health Department: _____

========== ***Refer to Report of Verified Case of Tuberculosis Instructions for Definitions*** ==========

DEMOGRAPHICS

Name, Address, City, State, Zip, Phone

Within city limits: ❑Yes ❑No

Date of Birth _____ Age_____
Sex at Birth _____
Race _____
❑Hispanic or Latino ❑Not Hispanic or Latino

Pediatric (less than 15 years old):
Country of Birth for Primary guardian_____
Name _____ Phone _____
Lived outside the U.S. for more than 2 months? ❑Yes ❑No ❑ Unknown
If yes, specify countries:_____

Diagnosed at ❑ Hospital ❑ Physician's Office
❑ Health Dept. ❑Unknown ❑N/A
Date reported to HD_____
Status at Diagnosis: ❑Alive ❑Dead
Date of death _____
Was TB a cause of death? ❑Yes ❑No ❑Unknown

Immigration Status at 1st Entry to U.S.: ❑ N/A (U.S. born) ❑ Immigrant visa ❑Family/Fiancé visa
❑ Student visa ❑Employment visa ❑ Tourist visa ❑ Refugee ❑ Asylee or Parolee
❑Other Immigration status ❑ Unknown

Any travel in the past 6 months? ❑ Yes ❑ No
If yes, what countries (if outside the US) or states (if inside the US) and for how long: _____

Place of Birth:
❑ **U.S. born** (born in 1 of 50 states, DC, U.S territories or to 1 parent of a U.S. citizen)
❑ **Foreign-born**
If foreign born, country of birth:_____
Date entered U.S._____

Primary Occupation Within the Past Year: ❑Health Care Worker ❑Correctional Facility Employee ❑Migrant/Seasonal Worker
❑Retired ❑Not Seeking Employment (student, homemaker, disabled) ❑Unemployed, but seeking employment ❑Other _____
❑Unknown **Employer** _____ Last date worked _____ Return to work date_____

EVER a resident of a correctional facility? ❑ Yes ❑ No If yes, year_____ ____ Location_____
Currently resident of correctional facility? ❑Yes ❑No **If yes, Location** _____
❑Federal Prison ❑ State Prison ❑ Local Jail ❑ Juvenile Correction Facility ❑ Other Correctional Facility _____
If yes, under custody of Immigration and Customs Enforcement (ICE)? ❑Yes ❑No

Resident of long term care facility? ❑Yes ❑No ❑ Unknown **EVER a resident of a Homeless Shelter?** Year_____ Location _____
❑Nursing home ❑Hospital based ❑Residential Facility ❑Mental Health Residential ❑Alcohol or Drug Treatment ❑Other Long-term Care Facility_____

Homeless within past year ❑Yes ❑No ❑Unknown	Depression ❑Yes ❑No ❑Unknown	Low literacy ❑Yes ❑No ❑Unknown
Inadequate housing ❑Yes ❑No ❑Unknown	Suicidal/homicidal thoughts ❑Yes ❑No ❑Unknown	Language barrier ❑Yes ❑No ❑Unknown
Inadequate income ❑Yes ❑No ❑Unknown	Paranoia ❑Yes ❑No ❑Unknown	Primary Language _____
Inadequate transportation ❑Yes ❑No ❑Unknown	Defiant ❑Yes ❑No ❑Unknown	Does not follow isolation ❑Yes ❑No❑Unknown
Domestic violence ❑Yes ❑No ❑Unknown	Erratic behavior ❑Yes ❑No ❑Unknown	Misses appointments ❑Yes ❑No❑Unknown
Child abuse ❑Yes ❑No ❑Unknown	Uncooperative ❑Yes ❑No ❑Unknown	Misses DOT appointments ❑Yes ❑No❑Unknown
Mental Health Diagnosis ❑Yes ❑No ❑Unknown	**Mental Health Referral** ❑Yes ❑No ❑Unknown	Reluctant to identify contacts ❑Yes ❑No❑Unknown

MEDICAL HISTORY

HIV status:
Test Offered ❑ Yes ❑ No
Refused Testing ❑ Yes ❑ No
Test done ❑ Yes ❑ No
Results:
❑Indeterminate
❑Unknown
❑Status Negative
❑Status Positive → CD4 _____
❑**Refer to MD/HIV Program**
On Antiretrovirals ❑ Yes ❑ No
If Yes, List:

PCP Prophylaxis ❑ Yes ❑ No

Females Only:
Last menstrual period _____
Contraceptive Method:
Pregnant? ❑ Yes ❑ No
Pregnancy test done? ❑ Yes ❑ No
Breastfeeding? ❑ Yes ❑ No

Primary Care Physician _____ ❑ **No Known Medical History**
Ever diagnosed with or treated for:
❑Diabetes Mellitus ❑Cancer (site) _____
❑Leukemia ❑Lymphoma ❑Hodgkins ❑Silicosis ❑Asbestos Exposure
❑Asthma ❑Bronchitis ❑Chest injury ❑Chest surgery ❑COPD
❑End Stage Renal Disease ❑Chronic liver disease
❑Tumor necrosis factor alpha (TNF) antagonists ❑Organ Transplant
❑Corticosteroid Therapy ❑Other immunosuppression (not HIV/AIDS)
❑Hypertension ❑Heart disease ❑Bleeding ❑Gastrectomy ❑Intestinal Bypass
❑Malabsorption syndrome ❑ Arthritis ❑Bone/Joint disorder
Hepatitis B : ❑Yes ❑ No Test ordered ❑ Yes ❑ No
Hepatitis C: ❑Yes ❑No Test ordered ❑ Yes ❑No

Ever received BCG vaccine? ❑ Yes ❑ No
❑ Packs of cigarettes smoke daily _____
❑ **Number of alcoholic beverages per day:** _____ **Type:** ❑ **Beer** ❑ **Wine** ❑ **Liquor**
❑Injecting drug use _____ ❑Non-injecting drug use_____
❑ Other _____
Recent hospitalization, specify details:_____
Medical Complications:

TB Symptoms present:
❑ Cough ❑ Weight loss
❑Fatigue ❑ Night sweats
❑ Fever ❑ Hemoptysis
❑ **No Symptoms**

Normal weight (lb/kg)_____ Current (initial) weight (lb/kg)_____
Height: _____ BMI: _____
Allergies:_____
Current Medications:_____

TUBERCULOSIS HISTORY

*Expul = Extrapulmonary * IGRA = Interferon-gamma release assay tests

Primary reason for TB evaluation: ❑TB Symptoms (❑ cough ❑ fever ❑ weight loss ❑ fatigue ❑ night sweats ❑ hemoptysis) ❑Abnormal Chest Radiograph (consistent with TB) ❑ Contact Investigation ❑ Targeted testing ❑ Health Care Worker ❑Employment/Administrative ❑ Immigration medical ❑ Incidental lab result ❑ Unknown

❑ Contact of MDR-TB Patient ❑ S+ ❑ S- ❑Expul*
❑ Contact of TB Patient ❑S+ ❑ S- ❑ Expul*
❑ Missed Contact ❑ No Known exposure

Contact to _____

Relationship_____

Environment _____

Priority: ❑High (❑Medical Risk) ❑Medium ❑Low

Last exposure date _____

❑ **Previous Diagnosis of TB Disease**
Date start treatment _____

Date stop treatment _____

Site of infection_____

Medications_____
_____
_____
_____

❑ Inadequate or incomplete TB treatment

❑ **Previous TST & Chest X-Rays**

Date _____

Result_____

Location_____

Date start treatment _____
Date stop treatment _____
Medication(s)_____
_____
❑ Incomplete LTBI Treatment
❑ Chest X-Ray (date) _____
Location _____

Initial TST
Date _____

Result _____

Follow-Up TST
Date _____

Result _____

IGRA*
Date: _____

(type)_____

Result _____

INITIAL BACTERIOLOGY SUMMARY

*(+) = Positive **(-) = Negative

INITIAL SPECIMEN:

Date _____ Site_____ code _____

❑ Sputum Smear ❑ Smear/Pathology/Cytology of Tissue & other body fluids
❑ **Public Health Laboratory** ❑ **Commercial Laboratory** ❑ **Other**

INITIAL RESULTS:
Smear
❑(+)* ❑ (-)** ❑ Pending
❑ Not done ❑ Unknown

Culture
❑(+)* ❑ (-)** ❑ Pending
❑ Not done ❑ Unknown

Nucleic Acid Amplification test:
❑(+)* ❑ (-)**
❑Indeterminate ❑ Pending
❑ Not done
❑ Unknown

INITIAL DRUG REGIMEN ORDERED BY NURSE PROTOCOL ❑ N/A

Case/suspect **Initial treatment:** **4 Drug Regimen - Option 1** **4 Drug Regimen Option 2**

LTBI/presumptive **Initial Treatment:** **Isoniazid 9 months** **Rifampin 4 months** **Rifampin 6 months** **Isoniazid/Rifapentine 12 weeks**

Medication Start Date_____ ❑ DOT ❑ Non- DOT ❑ VDOT

Isoniazid_____ mg ____tab PO ____x wk X____ mo #_____ (# doses____)
Rifampin_____ mg ____caps PO _____x wk X____ mo #____ (# doses____)
Pyrazinamide_____ mg ____tab PO ____x wk X____ mo #____ (# doses____)
Ethambutol_____ mg ____tab PO ____x wk X_____ mo #____ (# doses____)
Rifapentine_____ mg ___tab PO ___x wk X_____ mo #_____ (# doses____)
Pyridoxine_____ mg ___tab PO ____x wk X___ mo #_____ (# doses____)

***Example: INH 300mg, 1 tab, PO X 7 days/week X 9 mos, #30 tablets (#doses270)**

Comments:

Date Completed _____ **SIGNATURE**_____

Reason for Review: ❑Continuation/review ❑Follow up/Adverse Event ❑Window Period Prophylaxis ❑Treatment Completion ❑Other

Health Department: _____ **Phone:** _____

CURRENT DRUG REGIMEN

Date RX Started:_____ ❑ DOT ❑Non-DOT ❑ VDOT
❑Daily ❑ **Three Times Weekly** ❑Other _____

❑ Isoniazid _____ ❑ Rifampin _____
❑ Pyrazinamide _____ _____ ❑ Ethambutol _____
❑ Rifapentine_____ ❑ Other _____
❑ Other _____

TREATMENT COURSE

 # Months on Therapy _____ **# Doses to date** _____
Anticipated length of treatment _____
Anticipated completion date _____
❑**Treatment interruptions:** Date stopped _____
Date re-started _____ # Doses missed _____
Reason therapy stopped:
❑ Medical adverse reactions ❑ Liver Enzymes elevated
❑ Patient non-adherence ❑ Provider reasons
❑ Other_____

Comments:

Date Completed _____ **SIGNATURE** _____

CHEST RADIOGRAPHY & IMAGING STUDY

INITIAL
❑ Not done ❑ Unknown
Date _____
❑Chest views_____
❑CT scan/imaging_____
Remarks:

Interpretation
❑Normal ❑Not done❑Unknown
❑Abnormal :
❑ Pleural Effusion
❑ Evidence of Miliary TB
❑ Cavitary
❑ Non-cavitary:
❑Consistent with TB
❑ Inconsistent with TB

FOLLOW-UP
Date _____
❑Chest views_____
❑CT scan_____
❑ MRI _____
Status ❑ Stable ❑ Improving ❑Worsening ❑Unknown

PLAN AND DIAGNOSIS

Treatment:
❑Do not treat
❑Treatment complete
❑Refer to private Physician for diagnosis and/or treatment
❑ Start or continue window period prophylaxis
❑Discontinue window period prophylaxis
❑Start or continue treatment for LTBI
❑Discontinue treatment for LTBI
❑ Start or continue treatment for active TB disease
❑Discontinue treatment for active TB disease
❑Other_____

Site of TB Disease (select all that apply):
❑Pulmonary ❑Pleural ❑Laryngeal
❑Lymphatic: Cervical
❑Lymphatic: Intrathoracic
❑Lymphatic: Axillary
❑Lymphatic: Other
❑Lymphatic: Unknown
❑Bone and/or Joint
❑Genitourinary ❑Meningeal
❑Peritoneal
❑Site not stated
❑Other _____

Diagnosis:
❑ Latent TB Infection
❑Laboratory confirmed TB case
❑Clinical TB case
❑Recurrent TB case within 12 months after completion of therapy
❑Nontuberculous Mycobacterial Disease
❑ Other _____

Classification:
❑ 0 No exposure, not infected
❑ I Exposure, no infection
❑ II TB Infection, no disease
❑ III Current TB disease
❑ IV Previous TB disease
❑ V TB suspected

PHYSICIAN RECOMMENDATIONS

Medication: ❑Initial ❑Continuation ❑ Change of medications / ❑ Daily ❑ **Three times weekly** ❑ **Once Weekly** ❑Other _____❑ VDOT ❑ DOT ❑ Self Admin

❑ Isoniazid _____mg ____ tab(s) (_____ mg) PO _____days/wk. X _____ doses
❑ Rifampin 300 mg _____ cap(s) (_____mg) PO ___days/wk X ____doses
❑ Rifapentine _____mg _____tab(s) (_____ mg) PO ____days/wk X _____ doses
❑ Other _____
❑ Pyrazinamide 500 mg _____ tab(s) (_____mg) PO ____days/wk X ___ doses
❑ Ethambutol 400 mg ____ tab(s) (_____mg) PO ___days/wk X ____ doses
❑ Pyridoxine _____ mg 1 tablet PO _____days/wk X _____ doses
❑ Other _____

Recommendations: ❑ None ❑ Hospitalization ❑ Send old X-rays ❑ Send medical records
❑ Repeat TST (mo./yr._____) ❑ **IGRA** ***(mo./yr_____)*** ❑ Repeat Chest-X-ray (mo./yr._____) ❑ Re X-ray as clinically indicated
❑ Sputum AFB Smear/Culture daily X3 then weekly until sputum conversion, then monthly ❑ Sputum culture sensitivity ❑ 2 month sputum conversion

Perform baseline labs:	❑ AST	❑ ALT	❑ Liver profile	❑ Bilirubin	❑ Alkaline phosphatase	❑ CBC with platelet count
	❑ Serum creatinine		❑ Hepatitis B & C profile		❑ HIV counseling & testing	❑ CD4+count
Perform monthly labs:	❑ AST	❑ ALT	❑ Liver profile	❑ Bilirubin	❑ Alkaline phosphatase	❑ CBC with platelet count
	❑ Serum creatinine					

❑ Baseline and monthly visual acuity testing and red/green color discrimination while on Ethambutol ❑ Other _____
Comments:

Date Review Completed _____ **SIGNATURE**_____