DPH Georgia Department of Public Health TB PREVENTION AND CONTROL

Initial Report on Patient with Tuberculosis

Form 3141 (revised 01/2020)

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

The above identified patient has been evaluated for/diagnosed with tuberculosis (TB) and has given your name as his/her physician. Since TB is a communicable disease, the County Public Health Department is required by law to assure that every patient with TB receives proper treatment and contact identification. In order to adhere with Georgia Statutes and to assure quality care for this patient, your cooperation in completing, signing and returning this form is necessary. Please return to _____ County Public Health Department at _____ _____ by _____.

Patient newly diagnosed with TB? ❑ YES ❑ NO Patient previously diagnosed with TB, reactivated? ❑ YES ❑NO

TUBERCULOSIS EVALUATION

TB SKIN TEST/IGRA RESULTS

Date performed _____ ❑TB skin test _____mm ❑T-spot/Quantiferon Plus _____

RADIOGRAPH FINDINGS

Date performed _____ Results (please check): ❑ Normal ❑Abnormal ❑ Cavitary ❑Non-Cavitary
Additional Info/Other _____

LOCATION OF DISEASE (CHECK ALL THAT APPLY)

❑Pulmonary ❑Pleural ❑Lymphatic ❑Bone/Joint ❑Genitourinary ❑Miliary ❑Meningeal ❑Peritoneal
❑Other (please specify) _____

BACTERIOLOGICAL STATUS

Date Performed _____ Type of Specimen _____
Smear: Positive Negative Pending Not Performed
Culture: Positive Negative Pending Not Performed
If culture positive, Mycobacterium Tuberculosis or other (please specify) _____

CLINICAL/LAB RESULTS

Liver function tests/date: _____ Visual acuity _____ Color Discrimination _____ Hearing _____

MEDICATIONS **If not receiving TB medications explain why,** _____

Date started: _____	Isoniazid _____mg PO ____times/week	Doses received to date: ____
Date started: _____	Rifampin _____mg PO ____times/week	Doses received to date: ____
Date started: _____	Ethambutol _____mg PO ____times/week	Doses received to date: ____
Date started: _____	Pyrazinamide _____mg PO ____times/week	Doses received to date: ____
Date started: _____	Pyroxidine _____mg PO ____times/week	Doses received to date: ____
Date started: _____	_____mg PO ____times/week	Doses received to date: ____

CONTACT IDENTIFICATION

_____ I have already evaluated the persons exposed to TB by the above named patient and will complete and return the enclosed contact form.
_____ I prefer that the County Public Health Department provide contact identification and evaluation.

MEDICAL CARE Circle who will provide the following **PMD** = Private Medical Provider **HD** = Health Department

Patient Care	PMD	HD	Chest x-ray	PMD	HD	Hearing screen	PMD	HD
TB Medication[1]	PMD	HD	Liver function test	PMD	HD	Visual acuity/color	PMD	HD
Sputum collection	PMD	HD	Blood/Other labs	PMD	HD	Directly observed therapy[2]	PMD	HD

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 persons exposed to TB data. The County Public Health Department will fulfill its obligation in assuring 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 _____

[1]If the HD provides the patient's TB medications, a monthly assessment MUST be performed by the HD provider.

[2]Directly Observed Therapy is the **standard of care** for all patients being evaluated for/diagnosed with TB in Georgia.