

# Tuberculosis Services

#3121-R (Rev. 08/2014)

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 _____		Date of Birth _____ Age _____ Sex at Birth _____ Race _____ <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
Within city limits: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Pediatric (less than 15 years old):</b> Country of Birth for Primary guardian _____ Name _____ Phone _____ Lived outside the U.S. for more than 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify countries: _____		Diagnosed at <input type="checkbox"/> Hospital <input type="checkbox"/> Physician's Office <input type="checkbox"/> Health Dept. <input type="checkbox"/> Unknown <input type="checkbox"/> N/A Date reported to HD _____ Status at Diagnosis: <input type="checkbox"/> Alive <input type="checkbox"/> Dead Date of death _____ Was TB a cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>Immigration Status at 1<sup>st</sup> Entry to U.S.:</b> <input type="checkbox"/> N/A (U.S. born) <input type="checkbox"/> Immigrant visa <input type="checkbox"/> Family/Fiancé visa <input type="checkbox"/> Student visa <input type="checkbox"/> Employment visa <input type="checkbox"/> Tourist visa <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee or Parolee <input type="checkbox"/> Other Immigration status <input type="checkbox"/> Unknown		U.S. born (born in 1 of 50 states, DC, U.S territories, or to 1 parent of a U.S. citizen) <input type="checkbox"/> Yes <input type="checkbox"/> No Country of Birth _____
<b>Any travel in the past 6 months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what countries (if outside the US) or states (if inside the US) and for how long: _____		Foreign-born <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, country of birth _____ Date entered U.S. _____
<b>Primary Occupation Within the Past Year:</b> <input type="checkbox"/> Health Care Worker <input type="checkbox"/> Correctional Facility Employee <input type="checkbox"/> Migrant/Seasonal Worker <input type="checkbox"/> Retired <input type="checkbox"/> Not Seeking Employment (student, homemaker, disabled) <input type="checkbox"/> Unemployed, but seeking employment <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown <b>Employer</b> _____   Last date worked _____   Return to work date _____		
<b>EVER a resident of a correctional facility?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, year _____   Location _____ <b>Currently resident of correctional facility?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Federal Prison <input type="checkbox"/> State Prison <input type="checkbox"/> Local Jail <input type="checkbox"/> Juvenile Correction Facility <input type="checkbox"/> Other Correctional Facility _____ If yes, under custody of Immigration and Customs Enforcement (ICE)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Resident of long term care facility?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>EVER a resident of a Homeless Shelter?</b> Year _____   Location _____ <input type="checkbox"/> Nursing home <input type="checkbox"/> Hospital based <input type="checkbox"/> Residential Facility <input type="checkbox"/> Mental Health Residential <input type="checkbox"/> Alcohol or Drug Treatment <input type="checkbox"/> Other Long-term Care Facility _____		
Homeless within past year <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Inadequate housing <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Inadequate income <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Inadequate transportation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Domestic violence <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Child abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Depression <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Suicidal/homicidal thoughts <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Paranoia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Defiant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Erratic behavior <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Uncooperative <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Low literacy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Language barrier <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Primary Language _____ Does not follow isolation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Misses appointments <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Misses DOT appointments <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Reluctant to identify contacts <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

## MEDICAL HISTORY

<b>HIV status:</b> Test Offered <input type="checkbox"/> Yes <input type="checkbox"/> No Refused Testing <input type="checkbox"/> Yes <input type="checkbox"/> No Test done <input type="checkbox"/> Yes <input type="checkbox"/> No Results: <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown <input type="checkbox"/> Status Negative <input type="checkbox"/> Status Positive → CD4 _____ On Antiretrovirals <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, List: _____  PCP Prophylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Primary Care Physician</b> _____ <b>Ever diagnosed with or treated for:</b> <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Cancer (site) _____ <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Hodgkins <input type="checkbox"/> Silicosis <input type="checkbox"/> Asbestos Exposure <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Chest injury <input type="checkbox"/> Chest surgery <input type="checkbox"/> COPD <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Chronic liver disease <input type="checkbox"/> Tumor necrosis factor alpha (TNF) antagonists <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Corticosteroid Therapy <input type="checkbox"/> Other immunosuppression (not HIV/AIDS) <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart disease <input type="checkbox"/> Bleeding <input type="checkbox"/> Gastrectomy <input type="checkbox"/> Intestinal Bypass <input type="checkbox"/> G6-PD <input type="checkbox"/> Malabsorption syndrome <input type="checkbox"/> Arthritis <input type="checkbox"/> Bone/Joint disorder Hepatitis B : <input type="checkbox"/> Yes <input type="checkbox"/> No   Test ordered <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis C: <input type="checkbox"/> Yes <input type="checkbox"/> No   Test ordered <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Ever received BCG vaccine?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Packs of cigarettes smoke daily _____ <input type="checkbox"/> Ounces of beer drinks daily _____ <input type="checkbox"/> Ounces of wine drank daily _____ <input type="checkbox"/> Ounces of liquor drank daily _____ <input type="checkbox"/> Injecting drug use _____ <input type="checkbox"/> Non-injecting drug use _____ <input type="checkbox"/> Other _____ Recent hospitalization, specify details: _____ _____ Medical Complications: _____ _____
<b>Females Only:</b> Last menstrual period _____ Contraceptive Method: _____ Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnancy test done? <input type="checkbox"/> Yes <input type="checkbox"/> No Breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>TB Symptoms present:</b> <input type="checkbox"/> Cough <input type="checkbox"/> Weight loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Night sweats <input type="checkbox"/> Fever <input type="checkbox"/> Hemoptysis
	Normal weight (lb/kg) _____   Current (initial) weight (lb/kg) _____ Height: _____   BMI: _____ Allergies: _____ _____ Current Medications: _____



Name of client \_\_\_\_\_ DOB \_\_\_\_\_ #3121-R, Tuberculosis Services continued, p. 3  
Reason for Review:  Continuation/review  Follow up/Adverse Event  Window Period Prophylaxis  Treatment Completion  Other

Health Department: \_\_\_\_\_ Phone: \_\_\_\_\_

CURRENT DRUG REGIMEN	TREATMENT COURSE
Date RX Started: _____ <input type="checkbox"/> Daily <input type="checkbox"/> Twice Weekly <input type="checkbox"/> Isoniazid _____ <input type="checkbox"/> Pyrazinamide _____ <input type="checkbox"/> Rifapentine _____ <input type="checkbox"/> Other _____	# Months on Therapy _____ # Doses to date _____ Anticipated length of treatment _____ Anticipated completion date _____ <input type="checkbox"/> Treatment interruptions: Date stopped _____ Date re-started _____ # Doses missed _____ Reason therapy stopped: <input type="checkbox"/> Medical adverse reactions <input type="checkbox"/> Liver Enzymes elevated <input type="checkbox"/> Patient non-adherence <input type="checkbox"/> Provider reasons <input type="checkbox"/> Other _____

Comments: \_\_\_\_\_

Date Completed \_\_\_\_\_ SIGNATURE \_\_\_\_\_

**CHEST RADIOGRAPHY & IMAGING STUDY**

INITIAL	Interpretation	FOLLOW-UP
<input type="checkbox"/> Not done <input type="checkbox"/> Unknown Date _____ <input type="checkbox"/> Chest views _____ <input type="checkbox"/> CT scan/imaging _____ Remarks: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Not done <input type="checkbox"/> Unknown <input type="checkbox"/> Abnormal : <input type="checkbox"/> Pleural Effusion <input type="checkbox"/> Evidence of Miliary TB <input type="checkbox"/> Cavitory <input type="checkbox"/> Non-cavitory: <input type="checkbox"/> Consistent with TB <input type="checkbox"/> Inconsistent with TB	Date _____ <input type="checkbox"/> Chest views _____ <input type="checkbox"/> CT scan _____ <input type="checkbox"/> MRI _____ Status <input type="checkbox"/> Stable <input type="checkbox"/> Improving <input type="checkbox"/> Worsening <input type="checkbox"/> Unknown

<b>Treatment:</b> <input type="checkbox"/> Do not treat <input type="checkbox"/> Treatment complete <input type="checkbox"/> Refer to private Physician for diagnosis and/or treatment <input type="checkbox"/> Start or continue window period prophylaxis <input type="checkbox"/> Discontinue window period prophylaxis <input type="checkbox"/> Start or continue treatment for LTBI <input type="checkbox"/> Discontinue treatment for LTBI <input type="checkbox"/> Start or continue treatment for active TB disease <input type="checkbox"/> Discontinue treatment for active TB disease <input type="checkbox"/> Other _____	<b>Site of TB Disease (select all that apply):</b> <input type="checkbox"/> Pulmonary <input type="checkbox"/> Pleural <input type="checkbox"/> Laryngeal <input type="checkbox"/> Lymphatic: Cervical <input type="checkbox"/> Lymphatic: Intrathoracic <input type="checkbox"/> Lymphatic: Axillary <input type="checkbox"/> Lymphatic: Other <input type="checkbox"/> Lymphatic: Unknown <input type="checkbox"/> Bone and/or Joint <input type="checkbox"/> Genitourinary <input type="checkbox"/> Meningeal <input type="checkbox"/> Peritoneal <input type="checkbox"/> Site not stated <input type="checkbox"/> Other _____	<b>Diagnosis:</b> <input type="checkbox"/> Latent TB Infection <input type="checkbox"/> Laboratory confirmed TB case <input type="checkbox"/> Clinical TB case <input type="checkbox"/> Recurrent TB case within 12 months after completion of therapy <input type="checkbox"/> Nontuberculous Mycobacterial Disease <input type="checkbox"/> Other _____	<b>Classification:</b> <input type="checkbox"/> 0 No exposure, not infected <input type="checkbox"/> I Exposure, no infection <input type="checkbox"/> II TB Infection, no disease <input type="checkbox"/> III Current TB disease <input type="checkbox"/> IV Previous TB disease <input type="checkbox"/> V TB suspected
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**PHYSICIAN RECOMMENDATIONS**

Medication:  Initial  Continuation  Change of medications /  Daily  Twice weekly  Other \_\_\_\_\_  DOT  Self administer

<input type="checkbox"/> Isoniazid 300 mg ____ tab(s) (____ mg) PO ____ days/wk X ____ doses <input type="checkbox"/> Rifampin 300 mg ____ cap(s) (____ mg) PO ____ days/wk X ____ doses <input type="checkbox"/> Pyrazinamide 500 mg ____ tab(s) (____ mg) PO ____ days/wk X ____ doses <input type="checkbox"/> Ethambutol 400 mg ____ tab(s) (____ mg) PO ____ days/wk X ____ doses <input type="checkbox"/> Pyridoxine 25 mg 1 tablet PO ____ days/wk X ____ doses <input type="checkbox"/> Pyridoxine 50 mg 1 tablet PO BIW X ____ doses <input type="checkbox"/> Other _____	<input type="checkbox"/> Isoniazid 300 mg ____ tab(s) (____ mg) PO BIW X ____ doses <input type="checkbox"/> Rifampin 300 mg ____ cap(s) (____ mg) PO BIW X ____ doses <input type="checkbox"/> Pyrazinamide 500 mg ____ tab(s) PO (____ mg) BIW X ____ doses <input type="checkbox"/> Ethambutol 400 mg ____ tab(s) (____ mg) PO BIW X ____ doses <input type="checkbox"/> Pyridoxine 50 mg 1 tablet PO ____ days/wk X ____ doses
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Recommendations:  None  Hospitalization  Send old X-rays  Send medical records

Repeat TST (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

Perform monthly labs:  AST  ALT  Liver profile  Bilirubin  Alkaline phosphatase  CBC with platelet count

Serum uric acid  Serum creatinine  Hepatitis B & C profile  HIV counseling & testing  CD4+count

Baseline and monthly visual acuity testing and red/green color discrimination  Other \_\_\_\_\_

Comments: \_\_\_\_\_

Date Review Completed \_\_\_\_\_ SIGNATURE \_\_\_\_\_