Texas Department of Health
Tuberculosis Elimination Division
Report of Case and Patient Services

Date reported to health department ___/___/___
Date form sent to region ___/___/___
Date form sent to central office ___/___/___

☐ Initial Report ☐ Drug Resistance ☐ Followup or Medical Review ☐ Hospital Admission or Discharge

Name _____ DOB ___/___/___
(Last) (First) (Middle) MM DD YY

_____ SSN _____
Street Apt# City County Zip Code

Facility/Care Provider Name _____ _____
Facility responsible for patient care ☐ Public Health Clinic ☐ Private Physician ☐ Hospital ☐ Other (Specifiy) _____ Name of person completing this form

Signs/Symptoms at DX

Fever	☐ Y	☐ N
Chills	☐ Y	☐ N
Cough	☐ Y	☐ N
Productive Cough	☐ Y	☐ N
Hemoptysis	☐ Y	☐ N
Night Sweats	☐ Y	☐ N
Weight Loss (≥ 10%)	☐ Y	☐ N

Other:

Chest X-Ray
Date ___/___/___
Results: ☐ Normal ☐ Abnormal ☐ Not Done ☐ Unk
If Abnormal, check abnormality
☐ Cavitary
☐ Non-cavitary, consistent with TB
☐ Non-cavitary, not consistent with TB
Comments:

Status
☐ Stable
☐ Worsening
☐ Improving
☐ Unknown

If Pediatric TB Case (<15 Years Old)
Country of birth for primary guardians:
Guardian 1) _____
Guardian 2) _____
Patient lived outside US for > 3 months
☐ Yes ☐ No ☐ Unknown
If yes,
Country _____

Status ☐ New ☐ Recurrent ☐ Reopen
Prior Therapy ☐ Yes ☐ No Start Date ___/___/___
Stop Date ___/___/___

ATS Classification
☐ 0 No M. TB Exposure, Not TB Infected
☐ 1 M. TB Exposure, No Evidence of TB Infection
☐ 2 M. TB Infection, No Disease
☐ 3 M. TB Infection, Current Disease
☐ 4 M. TB, No Current Disease
☐ 5 M. TB Suspect, Diagnosis Pending

Predominant Site: (Class 3, 4) _____

Significant Sites other than Predominant

00	☐	Pulmonary	30	☐	Bone and/or Joint
10	☐	Pleural	40	☐	Genitourinary
20	☐	Lymphatic	50	☐	Miliary/Disseminated
21	☐	Cervical	60	☐	Meningeal
22	☐	Intrathoracic	70	☐	Peritoneal
23	☐	Other	80	☐	Other (Specify)_____

Other Diagnosis

Treatment for Active TB Disease Weight _____ Height _____
Regimen Start ___/___/___ Regimen Stop ___/___/___
Restart ___/___/___ Stop ___/___/___

Directly Observed Therapy (DOT) Doses:
☐ Yes ☐ No If no, specify reason _____

DOT Site: ☐ Clinic or other medical facility ☐ Field ☐ Both
Frequency: ☐ Daily ☐ Twice Weekly ☐ Three X's Weekly

☐	Isoniazid	____ mgs	☐	Rifater	____ mgs
☐	Rifampin	____ mgs	☐	Levofloxacin	____ mgs
☐	Rifamate	____ mgs	☐	Gatifloxacin	____ mgs
☐	Pyrazinamide	____ mgs	☐	Moxifloxacin	____ mgs
☐	Ethambutol	____ mgs	☐	Rifapentine	____ mgs
☐	Streptomycin	____ mgs	☐	Clofazimine	____ mgs
☐	Ethionamide	____ mgs	☐	Cycloserine	____ mgs
☐	Capreomycin	____ mgs	☐	PAS	____ mgs
☐	Amikacin	____ mgs	☐	B6	____ mgs
☐	Ciprofloxacin	____ mgs	☐	_____	____ mgs
☐	Ofloxacin	____ mgs	☐	_____	____ mgs
☐	Rifabutin	____ mgs	☐	_____	____ mgs

Prescribed for:_____ months Maximum refills authorized:_____

Closure:
Date ___/___/___ ____ % doses taken by DOT
____ # doses taken ____ # doses recommended
____ # months on Rx ____ # months recommended
☐ Completion of adequate therapy ☐ Lost to followup
☐ Patient chose to stop ☐ Adverse drug reaction
☐ Deceased (Cause) _____
☐ Moved out of state/country to: _____
Date referral sent to Austin ___/___/___
Provider decision: ☐ Pregnant ☐ Non-TB ☐ Other:_____

AFB Smear Results
Current ___/___/___ ☐ Negative ☐ Positive ☐ Pending ☐ Not done
Specimen type: ☐ sputum ☐ urine ☐ bronchial washing ☐ biopsy ☐ other
If biopsy or other, list anatomic site of specimen: _____
If other than sputa, type of exam _____
Collection date of initial positive AFB smear: ___/___/___
Collection date of first consistently negative AFB smear:___/___/___

Nucleic Acid Amplification Test
Current ___/___/___ ☐ Negative ☐ Positive ☐ Indeterminate ☐ Not done

Culture Results
Current ___/___/___ ☐ Negative ☐ Positive for M. TB ☐ Positive for Non-M. TB _____ ☐ Pending ☐ Not done
Specimen type: ☐ sputum ☐ urine ☐ bronchial washing ☐ biopsy ☐ other
If biopsy or other, list anatomic site of specimen: _____
Collection date of initial positive MTB culture: ___/___/___
Collection date of first consistently negative MTB culture:___/___/___
Sputum culture conversion documented? ☐ Yes ☐ No ☐ NA
If no, then reason

Susceptibility Results
Date initial susceptibility culture was collected ___/___/___
Initial culture was resistant to: ☐ Isoniazid ☐ Rifampin ☐ Ethambutol
Date last positive culture was collected ___/___/___
Last culture was resistant to: ☐ Isoniazid ☐ Rifampin ☐ Ethambutol
☐ Other quinolone(s)_____
☐ Other(s)_____

Reason Therapy Extending > 12 months: _____
Hospitalization Advised: ☐ Yes ☐ No Control Order ___/___/___
Quarantine Advised: ☐ Yes ☐ No Court Action ___/___/___
Return for chest x-ray: ___/___/___ Compliant: ☐ Yes ☐ No
Collect next sputum on: ___/___/___ Other lab studies:___/___/___
Return to MD clinic on: ___/___/___
Return to Nurse clinic on: ___/___/___

_____
Nurse Signature Date

_____
Physician Signature Date
_____Authorize nurse to obtain informed consent
General Comments:

ProtectTexas
Texas Department of Health

TB-400B (11/03)