Report of Case and Patient Services

Date reported to health department ____________
Date form sent to HSR ____________
Date form sent to central office ____________

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

Name ________________________________ (Last) (First) (Middle) DOB ____________

________________________________ Street Apt# City County Zip Code SSN ____________

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 (Check all that apply)
☐ Fever ☐ Weight Loss (≥ 10%)
☐ Chills ☐ Other ____________
☐ Cough
☐ Productive Cough
☐ Hemoptysis
☐ Night Sweats
Date of earliest onset ____________

Chest X-Ray
Date ____________
☐ Normal ☐ Abnormal ☐ Not Done ☐ Unk

CT Scan
Date ____________ ☐ Normal ☐ Abnormal

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, country: ____________
☐ No ☐ Unknown

Status ☐ New ☐ Recurrent ☐ Reopen
Prior Therapy ☐ Yes ☐ No
If yes, 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, 5): ____________

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

Other Diagnosis ____________

Treatment for Active TB Disease Weight _____ Height _____
Regimen Start ____________ Regimen Stop ____________
Restart ____________ Stop ____________
DOT: ☐ Yes ☐ No, specify reason: ____________
DOT Site: ☐ Clinic or other medical facility ☐ Field ☐ Both
Frequency: ☐ Daily ☐ Twice Weekly ☐ Three X's Weekly

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

Prescribed for: ________ months Maximum refills authorized: ________

Closure Date: ____________
☐ Completion of adequate therapy
☐ Patient chose to stop
☐ Deceased (Cause) ____________
☐ Moved out of state/country to: ____________
Date referral sent to central office: ____________
☐ Lost to followup
☐ Adverse drug reaction
Provider decision: ☐ Pregnant ☐ Non-TB ☐ Other: ________
Doses Taken _______ Doses taken by DOT _______
Doses Recommended _______ % Doses taken by DOT _______
Months on Rx _______ Months Recommended _______

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 ☐ Pending ☐ Not done
☐ Positive for M.TB ☐ Non-M.TB, specify ____________
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, specify reason: ____________

Susceptibility Results ☐ No Resistance
Initial culture collected: ____________ Resistant to: ☐ INH ☐ RIF ☐ EMB
Other resistance: ____________
Last pos. culture collected: ____________ Resistant to: ☐ INH ☐ RIF ☐ EMB
Other resistance: ____________

Reason Therapy Extending > 12 months: ____________
Hospitalization Advised: ☐ Yes ☐ No Control Order ____________
Compliant: ☐ Yes ☐ No
Quarantine Advised: ☐ Yes ☐ No Court Action ____________
Isolation: ☐ Yes, date: ____________ ☐ No, date released: ____________

Follow-up
Return for chest x-ray: ____________ Return to Nurse clinic: ____________
Collect next sputum: ____________ Other lab studies: ____________
Return to MD clinic: ____________

____
Nurse Signature Date

____
Physician Signature Date

_____ Authorize nurse to obtain informed consent

General Comments:

TB-400B (9/2018)