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 ☐ Hospital Admission
☐ Address Change ☐ Name Change (show new name and draw single line through old) ☐ Other Change (please circle)

SSN _____ Medicaid # _____ ID# _____ DOB ___/___/___
MM DD YY

Name _____ AKA _____
(Last) (First) (Middle)

_____
Street Apt# City County Zip Code Patient's Tel.#

Facility/Care Provider Name _____ _____
Initial Reporting Source ☐ Health Dept ☐ Private Physician ☐ Public Hospital ☐ VA Hospital Name of person completing this form
☐ Military Hospital ☐ TDCJ ☐ Other (Specify) _____

Country of Birth _____
If foreign born,
Date of entry into U.S. ___/___/___

Preferred Language _____

Notice of Arrival of Alien with TB Class
☐ A ☐ B1
☐ B2 ☐ B3

Reported at Death
☐ Yes ☐ No
If yes,
Death Date ___/___/___
Was TB cause of death
☐ Yes ☐ No ☐ Unk

Reported Out of State or Country
☐ Yes Specify _____ ☐ No

ETHNICITY ☐ Unknown
☐ Hispanic or Latino
☐ Not Hispanic or Latino

SEX
☐ Male
☐ Female

RACE (check all that apply)
☐ White
☐ Native Hawaiian or Pacific Islander
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Asian
☐ Unknown

OCCUPATION (within past 2 years)
☐ Unemployed during last 2 yrs ☐ Unknown
☐ Employed (If employed, check all that apply)
☐ Migrant/Seasonal Worker
☐ Health Care Worker (Specify) _____
☐ Correctional Emp ☐ Other Occupation
☐ Other
☐ Student ☐ Child
☐ Retiree ☐ Disabled
☐ Homemaker
☐ Institutionalized

Resident of Correctional Facility at Time of Dx ☐ Yes ☐ No ☐ Unknown Incarceration Date ___/___/___
If Yes ☐ Federal Prison ☐ State Prison ☐ County Jail ☐ City Jail ☐ Juvenile Correctional Facility ☐ ICE ☐ Other

Resident of Long Term Care Facility at Time of Dx ☐ Yes ☐ No ☐ Unknown
If Yes ☐ Nursing Home ☐ Hospital-Based Facility ☐ Residential Facility ☐ Mental Health Residential Facility
☐ Alcohol/Drug Treatment Facility ☐ Other Long Term Care Facility

Testing activities to find latent TB infections
☐ Patient referred, TB infection ☐ Project targeted testing ☐ Individual targeted testing ☐ Administrative: Not at risk for TB

POPULATION RISKS
☐ Low Income
☐ Inner-city resident
☐ Foreign born
☐ Binational (US-Mexico)
***Within past 2 years**
☐ Correctional employee*
☐ Health care worker*
☐ Prison/Jail inmate*
☐ Long-term facility for elderly/resident*
☐ Health care facility/resident*
☐ Shelter for homeless persons*
☐ Migrant farm worker*
☐ None of the above risks apply

MEDICAL RISKS
☐ Diabetes mellitus
☐ Alcohol Abuse (within past year)
☐ Tobacco use _____
☐ Silicosis
☐ Corticosteroids or other immunosuppressive therapy
☐ Gastrectomy or jejunoileal bypass
☐ age ≤ 5 years
☐ Recent exposure to TB (Contact to TB case)
☐ Contact to MDR-TB case
☐ Weight at least 10% less than ideal body weight
☐ Chronic malabsorption syndromes
☐ Leukemia
☐ Lymphoma
☐ Cancer of head
☐ Cancer of neck
☐ Drug abuse within past year:
☐ Injecting
☐ Non-injecting
☐ Unknown if injecting
☐ HIV seropositive (check only if laboratory confirmed)
☐ Tuberculin skin test conversion within 2 years
☐ Fibrotic lesions (on chest x-ray) consistent with old, healed TB
☐ Chronic renal failure
☐ Organ Transplant
☐ Other _____
☐ None of these medical risks apply

HIV TEST RESULTS
Date HIV Test ___/___/___
☐ Positive ☐ Negative
☐ Pending ☐ Refused
☐ Not Offered

Date CD4 Count ___/___/___
Results CD4 Count _____

TUBERCULIN SKIN TEST Documented history of positive TST? ☐ Yes ☐ No

___/___/___ ___ mm ☐ Positive ☐ Negative ☐ Not Read

___/___/___ ___ mm ☐ Positive ☐ Negative ☐ Not Read

PRIOR LTBI TREATMENT ☐ Yes ☐ No

Start Date ___/___/___

Stop Date ___/___/___

FOR TREATMENT OF LTBI ONLY

___/___/___ Date Normal Chest X-ray Weight _____ Height _____

DOPT: ☐ Yes, totally observed ☐ No, self-administered ☐ Both
DOPT Site: ☐ Clinic or medical facility ☐ Field ☐ Both
Frequency: ☐ Daily ☐ Twice Weekly ☐ Three X's Weekly

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
☐ 4 M. TB, No Current Disease

___/___/___ Date Regimen Start ___/___/___ Date Regimen Stop

___/___/___ Date Restart ___/___/___ Date Regimen Stop

☐ Isoniazid ___ mgs ☐ Other (specify) _____ ___ mgs
☐ Rifampin ___ mgs ☐ Other (specify) _____ ___ mgs
☐ B6 ___ mgs Prescribed for: ___ months Maximum refills authorized: ___ Physician Signature Date

CLOSURE: Date ___/___/___ ☐ Completion adequate therapy ___ # months on Rx ___ # months recommended
☐ Lost to followup ☐ Patient chose to stop ☐ Deceased (Cause) _____
☐ Adverse Drug Reaction ☐ Moved out of state/country to: _____
Provider decision: ☐ Pregnant ☐ Non-TB ☐ Other: _____

ProtectTexas
Texas Department of Health

TB-400A (11/03)