

**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 _____ (Last) _____ (First) _____ (Middle) DOB _____/_____/_____
 MM DD YY

Street _____ Apt# _____ City _____ County _____ Zip Code _____
 Facility/Care Provider Name _____
 Facility responsible for patient care Public Health Clinic Private Physician Hospital
 Other (Specify) _____ Name of person completing this form _____

Signs/Symptoms at DX Fever <input type="checkbox"/> Y <input type="checkbox"/> N Chills <input type="checkbox"/> Y <input type="checkbox"/> N Cough <input type="checkbox"/> Y <input type="checkbox"/> N Productive Cough <input type="checkbox"/> Y <input type="checkbox"/> N Hemoptysis <input type="checkbox"/> Y <input type="checkbox"/> N Night Sweats <input type="checkbox"/> Y <input type="checkbox"/> N Weight Loss (≥ 10%) <input type="checkbox"/> Y <input type="checkbox"/> N Other: _____	Chest X-Ray Date _____/_____/_____ Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Done <input type="checkbox"/> Unk If Abnormal, check abnormality <input type="checkbox"/> Cavitory <input type="checkbox"/> Stable <input type="checkbox"/> Non-cavitory, consistent with TB <input type="checkbox"/> Worsening <input type="checkbox"/> Non-cavitory, not consistent with TB <input type="checkbox"/> Improving Comments: _____ <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, Country _____
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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: _____

 TB-400B (11/03)