Texas Department of State Health Services

Date reported to health department

Date form sent to PHR

Date form sent to central office

Report of Case and Patient Services

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

Name (Last) (First) (Middle)   DOB

SSN

Street   Apt#   City   County   Zip Code

Facility/Care Provider Name: Name of person completing this form:

Facility responsible for patient care: Public Health Clinic   Private Physician   Hospital   Other (specify):

Signs/Symptoms at DX (Check all that apply)

Fever   Weight Loss (≥ 10%)
Chills
Cough   Other:
Productive Cough
Hemoptysis
Night Sweat

Date of earliest onset

Chest X-Ray   **CT Scan**   Date

Normal   Abnormal   Not Done   Unknown

If Abnormal, check abnormality

Cavitary
Non-cavitary, consistent with TB
Non-cavitary, not consistent with TB

Status

Stable
Worsening
Improving
Unknown

Comments:

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	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

DOT: Yes   No, specify reason:

DOT Site: Clinic or other medical facility   Field   VDOT

Frequency: Daily:5x/week   Daily: 7x/week   2x/week   3x/week

Isoniazid	mgs	Rifater	mgs
Rifampin	mgs	Levofloxacin	mgs
Rifamate	mgs	Moxifloxacin	mgs
Pyrazinamide	mgs	Rifapentine	mgs
Ethambutol	mgs	Bedaquiline	mgs
Streptomycin	mgs	Clofazimine	mgs
Ethionamide	mgs	Cycloserine	mgs
Capreomycin	mgs	Linezolid	mgs
Amikacin	mgs	PAS	mgs
Ciprofloxacin	mgs	B6	mgs
Ofloxacin	mgs		mgs
Rifabutin	mgs		mgs

Prescribed for: months   Maximum refills authorized:

Closure Date:

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 central office:

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:

General Comments:

Nurse Signature   Date

Physician Signature   Date

Authorize nurse to obtain informed consent