SAVE PRINT CLEAR

TEXAS Health and Human Services | Texas Department of State Health Services

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 _____ DOB _____
(Last) (First) (Middle)

_____ SSN _____
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 (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

If Abnormal, check abnormality
☐ Cavitary
☐ Non-cavitary, consistent with TB
☐ Non-cavitary, not consistent with TB
Comments:

CT Scan
Date _____
☐ Normal ☐ Abnormal

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	☐ 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: _____
☐ 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: _____

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)