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 PHR _____
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: _____ 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
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 ☐ 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

TB-400B (4/2020)