

**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 _____ (Last) _____ (First) _____ (Middle) _____ AKA _____

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. _____ / _____ / _____	Notice of Arrival of Alien with TB Class <input type="checkbox"/> A <input type="checkbox"/> B1 <input type="checkbox"/> B2 <input type="checkbox"/> B3	Reported at Death <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Death Date _____ / _____ / _____ Was TB cause of death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Reported Out of State or Country <input type="checkbox"/> Yes Specify _____ <input type="checkbox"/> No
Preferred Language _____	ETHNICITY <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female

RACE (check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Unknown	OCCUPATION (within past 2 years) <input type="checkbox"/> Unemployed during last 2 yrs <input type="checkbox"/> Unknown <input type="checkbox"/> Employed (If employed, check all that apply) <input type="checkbox"/> Migrant/Seasonal Worker <input type="checkbox"/> Student <input type="checkbox"/> Child <input type="checkbox"/> Health Care Worker (Specify) _____ <input type="checkbox"/> Retiree <input type="checkbox"/> Disabled <input type="checkbox"/> Correctional Emp <input type="checkbox"/> Other Occupation <input type="checkbox"/> Homemaker <input type="checkbox"/> Institutionalized
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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 <input type="checkbox"/> Low Income <input type="checkbox"/> Inner-city resident <input type="checkbox"/> Foreign born <input type="checkbox"/> Binational (US-Mexico) *Within past 2 years <input type="checkbox"/> Correctional employee* <input type="checkbox"/> Health care worker* <input type="checkbox"/> Prison/Jail inmate* <input type="checkbox"/> Long-term facility for elderly/resident* <input type="checkbox"/> Health care facility/resident* <input type="checkbox"/> Shelter for homeless persons* <input type="checkbox"/> Migrant farm worker* <input type="checkbox"/> None of the above risks apply	MEDICAL RISKS <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Alcohol Abuse (within past year) <input type="checkbox"/> Tobacco use _____ <input type="checkbox"/> Silicosis <input type="checkbox"/> Corticosteroids or other immunosuppressive therapy <input type="checkbox"/> Gastrectomy or jejunioleal bypass <input type="checkbox"/> age < 5 years <input type="checkbox"/> Recent exposure to TB (Contact to TB case) <input type="checkbox"/> Contact to MDR-TB case <input type="checkbox"/> Weight at least 10% less than ideal body weight <input type="checkbox"/> Chronic malabsorption syndromes	<input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Cancer of head <input type="checkbox"/> Cancer of neck <input type="checkbox"/> Drug abuse within past year: <input type="checkbox"/> Injecting <input type="checkbox"/> Non-injecting <input type="checkbox"/> Unknown if injecting <input type="checkbox"/> HIV seropositive (check only if laboratory confirmed) <input type="checkbox"/> Tuberculin skin test conversion within 2 years <input type="checkbox"/> Fibrotic lesions (on chest x-ray) consistent with old, healed TB	<input type="checkbox"/> Chronic renal failure <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Other _____ <input type="checkbox"/> None of these medical risks apply
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ / _____ / _____ mm <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Read _____ / _____ / _____ mm <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Read	PRIOR LTBI TREATMENT <input type="checkbox"/> Yes <input type="checkbox"/> No Start Date _____ / _____ / _____ Stop Date _____ / _____ / _____
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FOR TREATMENT OF LTBI ONLY
DOPT: Yes, totally observed No, self-administered Both Date Normal Chest X-ray _____ / _____ / _____ Weight _____ Height _____
DOPT Site: Clinic or medical facility Field Both **ATS Classification**
Frequency: Daily Twice Weekly Three X's Weekly
 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: _____