TEXAS HANSEN'S DISEASE ENCOUNTER FORM

Visit Date: _____
Name: _____
SSN: _____ DOB: _____
Address: _____
_____
Phone: _____

❑ Male
❑ Female

Type of Insurance:
_____

HD Type: _____ Year Dx: _____
Visit Type: ❑ PMD ❑ Clinic ❑ PHN
M.D./Clinic: _____
Address: _____
_____
Phone: _____

Last Skin Smear: _____
Result: _____

Last Biopsy: _____
Result: _____

Drug/Dosage	Frequency	Date Started	Date Stopped	Reason Discontinued
Dapsone				
Rifampin				
Clofazimine				

Client Education:
- ❑ Compliance to Chemotherapy
- ❑ Cause/Transmission
- ❑ Drug Regimen/Toxicity
- ❑ Reaction(s)
- ❑ Care Hands/Feet/Eyes
- ❑ Acceptance

Monitors:
- ❑ Hands
- ❑ Feet
- ❑ Eyes

May attach body chart

Medical Compliance/Tolerance:

Reactional State:
- ❑ ENL
- ❑ Reversal
- ❑ Other

Comments:

Allergies:

Progress Notes:

Medications	Dose	Frequency	Quantity
Dapsone			
Rifampin			
Clofazimine			

Refill:
- ❑ 2 Months
- ❑ 3 Months
- ❑ 6 Months
- ❑ 1 Year

Next Visit:

Central Office Use Only:

Laboratory Tests:

Initial Visit
- ❑ CBC
- ❑ VDRL
- ❑ Ova & Parasites
- ❑ SMAC (CMP)
- ❑ G-6-PD
- ❑ UA
- ❑ Occult Blood

Multidrug Therapy
- ❑ Liver Function
- ❑ CBC
- ❑ Bilirubin
- ❑ Alkaline Phos.
- ❑ SMAC (CMP)
- ❑ UA
- ❑ SGOT
- ❑ SGPT

Monotherapy
- ❑ CBC
- ❑ UA

Thalidomide
- ❑ CBC
- ❑ Platelets
- ❑ Eosinophil Count

PHN's Signature: _____ Date: _____

Address: _____ Physician's Signature: _____