

**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) \_\_\_\_\_

<b>Country of Birth</b> _____ If foreign born, Date of entry into U.S. _____ / _____ / _____  <b>Preferred Language</b> _____	<b>Notice of Arrival of Alien with TB Class</b> <input type="checkbox"/> A <input type="checkbox"/> B1  <input type="checkbox"/> B2 <input type="checkbox"/> B3	<b>Reported at Death</b> <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	<b>Reported Out of State or Country</b> <input type="checkbox"/> Yes Specify _____ <input type="checkbox"/> No  <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"><b>ETHNICITY</b> <input type="checkbox"/> Unknown</td> <td style="width:50%;"><b>SEX</b></td> </tr> <tr> <td><input type="checkbox"/> Hispanic or Latino</td> <td><input type="checkbox"/> Male</td> </tr> <tr> <td><input type="checkbox"/> Not Hispanic or Latino</td> <td><input type="checkbox"/> Female</td> </tr> </table>	<b>ETHNICITY</b> <input type="checkbox"/> Unknown	<b>SEX</b>	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Male	<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Female
<b>ETHNICITY</b> <input type="checkbox"/> Unknown	<b>SEX</b>								
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Male								
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Female								

<b>RACE (check all that apply)</b> <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	<b>OCCUPATION (within past 2 years)</b> <input type="checkbox"/> Unemployed during last 2 yrs <input type="checkbox"/> Unknown <input type="checkbox"/> Other <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"/> _____ <input type="checkbox"/> Institutionalized
---	--

**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

<b>POPULATION RISKS</b> <input type="checkbox"/> Low Income <input type="checkbox"/> Inner-city resident <input type="checkbox"/> Foreign born <input type="checkbox"/> Binational (US-Mexico) <b>*Within past 2 years</b> <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	<b>MEDICAL RISKS</b> <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 jejunioileal 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	<b>HIV TEST RESULTS</b> Date HIV Test _____ / _____ / _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Refused <input type="checkbox"/> Not Offered  Date CD4 Count _____ / _____ / _____ Results CD4 Count _____
---	--	---

<b>TUBERCULIN SKIN TEST</b> 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	<b>PRIOR LTBI TREATMENT</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  Start Date _____ / _____ / _____ Stop Date _____ / _____ / _____
--	---

**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  
 Frequency:  Daily       Twice Weekly       Three X's Weekly      **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  
 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: \_\_\_\_\_