NHDP ANNUAL FOLLOW UP FORM

Date of Exam____/____/____

Name: _____ **Sex:** _____ **Date of Birth** ____/____/____

NHDP Clinic OR City / State: _____

Treating Physician: _____ **Telephone or E-mail:** _____

	Hands				Feet					Eyes			
	Right		Left		Right		Left			Right		Left	
	Yes	No	Yes	No	Yes	No	Yes	No		Yes	No	Yes	No
Loss of Sensation?	☐	☐	☐	☐	☐	☐	☐	☐	Blink abnormal?	☐	☐	☐	☐
Visible deformity?	☐	☐	☐	☐	☐	☐	☐	☐	Visible abnormality? (see instructions below)	☐	☐	☐	☐

Was patient treated for leprosy reaction (e.g. prednisone required) during the last year? ☐ Yes ☐ No

Status regarding completion of minimum treatment of HD (check one)

1. Continuing in first year of MDT. ☐
2. Continuing in second year of MDT. ☐
3. Completed *minimum course of MDT. ☐
   Month and year _____
4. Lost to follow up ☐
5. Deceased ☐
6. Other (re-treatment after relapse, etc.) ☐

*Minimum=1 yr. for PB disease, 2 yrs. for MB disease

INSTRUCTIONS:

Disability: Eyes, Hands & Feet:

For each eye, hand and foot, check Yes or No for:

Loss of sensation:

Hands & Feet: Y = loss of sensation at 2 points

Eyes: Y = blinking is abnormal (very infrequent)
Normal eyes = No

Visible deformity:

Hands & Feet: Y = Muscle wasting, clawing of fingers, wounds or ulcers

Eyes: Y = Lagophthalmos, Reduced vision, Uveitis, etc.

For NHDP clinics using monofilaments:

Hands: Y = inability to feel 2g filament

Feet: Y = inability to feel 10g filament

Leprosy reaction during the last year: Y = **ANY** reaction requiring corticosteroids

This form must be completed on or near the anniversary date of <u>diagnosis</u> for each patient being actively followed by the clinic and mailed to:

Texas Department of State Health Services
Tuberculosis and Hansen's Disease Services Branch
Mail Code: 1939 PO Box 149347
Austin, TX 78714-9347

DSHS REVISED FROM NHDP FORM 208
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