



Hansen’s Disease Consultation Request Form

The Texas Department of State Health Services (DSHS) offers consultation for licensed healthcare providers (LHPs) managing patients and contacts with known or suspected Hansen’s disease (HD). LHPs who will manage the patient and seek a consultation should submit this form. NOTE: This form is NOT for reporting HD or referring a patient to a DSHS-supported HD clinic for medical management. For reporting or referring to a DSHS HD clinic, visit dshs.texas.gov/hansens-disease-leprosy.

Directions: Complete all relevant fields, provide supporting documentation and attachments, and fax to 512-989-4010. To confirm receipt, email hdpcr@dshs.texas.gov or call 512-806-4334. Once received, a DSHS nurse will notify the preferred contact. NOTE: DSHS HD clinics must submit via GlobalScape or encrypted email.

Requestor Information	
Name of Licensed Healthcare Provider (LHP)	
Name of Clinic or Affiliation	
Name and Title of Person Submitting Consult (if other than LHP)	
Date Submitted to DSHS	
Preferred Contact Name, Title, and Contact Information for Response	Name and Title (if other than LHP): Phone: Email: Preferred communication: <input type="checkbox"/> Phone <input type="checkbox"/> Email
Availability to speak with consultants (include dates and times)	
Reason for Consult	
<input type="checkbox"/> Suspected HD, diagnosis confirmation <input type="checkbox"/> History of HD (possible recurrent or relapse disease) <input type="checkbox"/> Treatment guidance or initiation of HD therapy <input type="checkbox"/> Management of reactions (ENL, Type 1, etc.) <input type="checkbox"/> Follow-up care or disability management <input type="checkbox"/> Recommendations for reconstructive surgery or rehabilitation	<input type="checkbox"/> Need recommendations for drug side effects <input type="checkbox"/> Need recommendations for managing disability or deformity <input type="checkbox"/> Contact – need recommendations for evaluation and/or treatment <input type="checkbox"/> Other, specify:
Consult Urgency:	<input type="checkbox"/> Routine (response within 5 days) <input type="checkbox"/> Urgent (response within 3 days)

Patient Information: <i>Leave blank if UNK; Fields with * are Required</i>			
Last Name*:	First Name*:	DOB*:	
Street Address:			
City:	Zip:	County*:	State*:



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Current HD Type: <input type="checkbox"/> N/A; diagnosis pending <input type="checkbox"/> Lepromatous (LL) <input type="checkbox"/> Borderline Lepromatous (BL) <input type="checkbox"/> Mid-Borderline (BB) <input type="checkbox"/> Borderline Tuberculoid (BT) <input type="checkbox"/> Tuberculoid (TT) <input type="checkbox"/> Indeterminate (I)	HD Status if Known: <input type="checkbox"/> Active (A) <input type="checkbox"/> Observation (OBS) <input type="checkbox"/> Inactive (IA) <input type="checkbox"/> Complication (COMP) <input type="checkbox"/> Suspect (S) <input type="checkbox"/> Deceased (D) <input type="checkbox"/> Contact (C) <input type="checkbox"/> New Case (NC) <input type="checkbox"/> Lost to Follow-up (LTFU)	Reactional State: <input type="checkbox"/> Type 1- Reversal <input type="checkbox"/> Type 2- Erythema Nodosum Leprosum (ENL) <input type="checkbox"/> Lucio's Phenomenon <input type="checkbox"/> Uncertain
Biopsy Location on Body and Date:	Result:	

Medication Information: *Include Comments as They Relate to Consultation Reason*

Current HD Treatment: Monthly Rifampin/Moxifloxacin/Minocycline (RMM)
 Daily Multi-Drug Therapy (MDT) WHO Protocol Prophylaxis Reaction None
 Other:

Medication Treatment Length: Less than 1 year 1 year Less than 2 years 2 years

Drug	Dosage	Frequency	Start Date	Stop Date	Reason Stopped	Re-start Date	Re-stop Date	Comments (incl side effects)
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Multi-Drug Therapy

Dapsone								
Rifampin								
Clofazimine								
Clarithromycin								
Minocycline								
Moxifloxacin								
Other:								
Other:								

Reaction Therapy

Clofazimine								
Methotrexate								
Prednisone								
Thalidomide								
Other:								
Other:								

Other Prescribed Medications



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Monitoring Results: *Attach All Relevant Laboratory Results and Assessments Performed*

Baseline

Biopsy:

- Fite Stain PCR Skin smear
- CMP CBC w/diff ESR
- CRP G6PD Vit D
- IGRA Hepatitis B* Hepatitis C*
- Other:

Other Labs:

- BMP/CMP CBC
- AST/ALT Bilirubin
- Alkaline Phos Eosinophil Count
- Other:

Hand Screens – Date and Results:

Foot Screens Date and Results:

Eye Screens Date and Results:

Consultation Checklist and Consult Details

Include a clearly stated reason for consultation with relevant details and notes for the medical consultant's review. Ensure you include all checklist items in this form and attach it when submitting.

- Clearly stated reason for consultation.
- Patient demographics
- Complete clinical history and physical exam findings
- Relevant diagnostic studies and lab results
- Photographs (optional, anonymized if required)
- Current and previous treatment details
- Public health actions and social history (if applicable)
- All sections of the Consultation Request Form are completed.

Note: for DSHS HD Clinics, attach any relevant forms, including C-12, HD 400s, and Screens



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Consultation Checklist and Consult Details, *Continued*

Include relevant assessments, past medical history, HD risk factors, medications, lab results, etc.



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******* MEDICAL CONSULTANT Section ONLY *******

Date Consult Request Received:

Medical Consultant:

Dr. Annie Kizilbash Dr. Adriana Vasquez

Other:

Consultation Documentation (include consultation results, follow up needed)

Initial Consult, Date:

Follow-Up Consult, Date:

Notes and Recommendations:



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Medical Consultant Documentation ONLY, continued.

Signature and Date: