TEXAS Health and Human Services | Texas Department of State Health Services

SAVE PRINT CLEAR

DSHS Tuberculosis Unit
Cohort Review Presentation Form

Quarter: ☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4	Cohort Year:	Presentation Date:
Primary Case Manager:	Contact Investigator:	Treating Physician:

Section 1: Patient Information

RVCT #:	Date of Birth:
Patient Name:	Gender: ☐ Male ☐ Female
Date Case was Counted:	Country of Birth:

Medical Risks (check all that apply):

- ☐ Diabetes Mellitus
- ☐ Alcohol Abuse (within past year)
- ☐ Tobacco Use
- ☐ Silicosis
- ☐ Corticosteroids or Other Immunosuppressive Therapy
- ☐ Gastrectomy or Jejunoileal Bypass
- ☐ Age < 5 Years
- ☐ Recent Exposure to TB (contact to TB case)
- ☐ Contact to MDR-TB
- ☐ Weight at Least 10% Less Than Ideal Body Weight
- ☐ Chronic Malabsorption Syndromes
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Cancer of Head
- ☐ Cancer of Neck
- ☐ Drug Abuse within Past Year
- ☐ TB Test Conversion in Last 2 Years
- ☐ Fibrotic Lesions (on chest X-ray) Consistent with Old, Healed TB
- ☐ Chronic Renal Failure
- ☐ Organ Transplant
- ☐ Other: _____

Code 900: ☐ Not Offered ☐ Refused
Collection Date: _____ Results: ☐ Positive ☐ Negative ☐ Pending
CD4 Count, if positive:

Section 2: Diagnostic Information

Disease Site:	Initial Chest X-ray Date: _____ ☐ Normal ☐ Abnormal ☐ Abnormal/Cavitary ☐ Not Done
Collection Date of Initial Positive AFB Smear:	Collection Date of Initial Positive MTB Culture:

Resistance: ☐ Yes ☐ No If Yes, Resistant to:

Section 3: Treatment Completion Information

Treatment Start Date:	Treatment Completion Date:
Collection Date of First Consistently Negative AFB Smear:	Collection Date of First Consistently Negative MTB Culture:

If Treatment Not Completed, check all that apply:

- ☐ Still on Therapy (Planned Completion Date: _____)
- ☐ Treatment Interruption (☐ Adverse Reaction ☐ Patient Non-adherence ☐ Provider Decision)
- ☐ MDR
- ☐ Lost
- ☐ Reported at Death
- ☐ Inter-jurisdictional Transfer (To: _____ Date: _____)
- ☐ Other:
- ☐ Refused (Reason:_____)
- ☐ Died (Date: _____)
- ☐ Moved out of Country(To: _____)

If Not on DOT Explain:
Number of Recommended Doses: Number of Doses Taken:

Section 4: Contact Investigation Results	
Genotyped: □ Yes □ No If Yes, wgMLSType:	
Number of Contacts Identified:	Number of Contacts Evaluated:
Number of Documented Prior Positives:	
Number of Contacts Infected without TB Disease:	
Number of Contacts Identified as AFB Smear Positive:	
Number of Contacts Identified with TB Disease:	
Number of Contacts Eligible for Treatment of TB Infection (TBI):	
Number of Contacts that Started Treatment for TBI: Recent Documented Conversions: _____ Children ≤ 5 Years:_____ Known HIV+ Status: _____	
Number of Contacts Currently on Treatment for TBI:	
Number of Contacts that Completed Treatment for TBI: Recent Documented Conversions: _____ Children ≤ 5 Years:_____ Known HIV+ Status: _____	
Number of Contacts that Did Not Complete Treatment for TBI Due To: _____Still on Treatment _____Adverse Reactions _____Died _____Moved _____Refused _____Lost _____Provider Decision (Unable to Monitor Patient Care) _____Other:	
Percentage of Contacts Infected: (Formula: Number of Contacts Infected – Prior Positives x 100%) Number Evaluated – Prior Positives	