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

Medical Consultation Request Form

Date reported to the health department

Date Submitted:	Submitter Name:	
LHP* Requesting Consult:	Submitter Location:	
Nurse Case Manager *(if different from submitter):*		
Briefly Describe Reason for Consult:		

Demographics

Patient Name:	Date of Birth:	Age:
Sex: ☐ Male ☐ Female		

Patient History

Current ATS Classification: ☐ 0 – No M. TB Exposure, Not TB Infected ☐ 1 – M. TB Exposure, No Evidence of TB Infection	☐ 3 – M. TB Infection, Current Disease ☐ 4 – M. TB, No Current Disease ☐ 5 – M. TB Suspect, Diagnosis Pending
History of Present Illness (HPI):	
Baseline Weight/BMI:	Current Weight:

TB Signs and Symptoms:

☐ Cough: ☐ Productive ☐ Non-productive	☐ Fever/Chills	☐ Fatigue
☐ SOB	☐ Night sweats	☐ Other:
☐ Chest Pain	☐ Loss of appetite	
☐ Hemoptysis	☐ Weight loss	

Co-morbidities:	Non-TB Medications:

TB History and Risk Factors (*e.g., previous TB treatment with regimen details, foreign born, incarceration, etc.*):

Diagnostics

Test type *includes: smear, pathology/cytology, NAA, culture, TST, IGRA*
Specimen source *includes: sputum or other specific anatomic site (e.g., CSF fluid, gastric aspirate, etc.)*

Date Collected	Test Type/Specimen Source	Results

Date of Sputum Smear Conversion:
Date of Sputum Culture Conversion:

**LHP is the licensed healthcare provider (e.g., treating physician) medically managing the patient*

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

Medical Consultation Request Form

Date reported to the health department

☐ Chest X-Ray ☐ Other Imaging, Specify:
Date: ☐ Normal ☐ Cavitary ☐ Non Cavitary
Read:

Date: ☐ Normal ☐ Cavitary ☐ Non Cavitary
Read:

Laboratory Testing

(attach results or indicate any concerns below)

HIV Results: ☐ Negative ☐ Positive CD4: Viral load:
Serum Drug Levels: ☐ Yes ☐ No ☐ Pending
Lab Results *(list significant results, or submit copy of labs)*:

Toxicity Assessments

(provide abnormal results or changes; attach abnormal results if applicable)

Date of Most Recent Assessment:
☐ Normal ☐ Abnormal
Trends/Concerns:

Treatment

(provide drug-o-gram or equivalent if drug resistant)

Initial Treatment Start Date: Initial Treatment Stop Date:
Administration: ☐ DOT ☐ Other Frequency: ☐ 5x/week ☐ 7x/week ☐ 3x/week

☐ INH _____ mg	☐ BDQ _____ mg	☐ LFX _____ mg	☐ Other _____ mg
☐ RIF _____ mg	☐ Pa _____ mg	☐ CFZ _____ mg	☐ Other _____ mg
☐ PZA _____ mg	☐ LZD _____ mg	☐ CS _____ mg	
☐ EMB _____ mg	☐ MFX _____ mg	☐ B6 _____ mg	

If different from above:
Treatment Start Date: Treatment Stop Date:
Administration: ☐ DOT ☐ Other Frequency: ☐ 5x/week ☐ 7x/week ☐ 3x/week

☐ INH _____ mg	☐ BDQ _____ mg	☐ LFX _____ mg	☐ Other _____ mg
☐ RIF _____ mg	☐ Pa _____ mg	☐ CFZ _____ mg	☐ Other _____ mg
☐ PZA _____ mg	☐ LZD _____ mg	☐ CS _____ mg	
☐ EMB _____ mg	☐ MFX _____ mg	☐ B6 _____ mg	

Any Additional Comments for this Consultation Request: