



Report of Case and Patient Services

Date reported to health department

Date form sent to PHR

Date form sent to central office

Initial Report, Hospital Admission, Address Change, Name Change, Other Change, SSN, Medicaid #, ID#, DOB, Name (Last, First, Middle, Alias), Street, Apt#, City, County, Zip Code, Patient's Tel.#, Facility/Care Provider Name, Name of person completing this form, Initial Reporting Source, Health Dept, Private Physician, Public Hospital, VA Hospital, Military Hospital, TDCJ, Other (Specify):

Country of Birth, Date of U.S. Entry, Eligible for U.S. Citizenship/Nationality at Birth?, Preferred Language, Notice of Arrival of Alien with TB Class, Reported at Death, Reported Out of State or Country, ETHNICITY, SEX

RACE (check all that apply), OCCUPATION (within past 2 years), Employment status, Health Care Worker, Migrant/Seasonal Worker, Correctional Employee, Other Occupation

Initial Reason Evaluated for TB: Contact Investigation, Screening, TB Symptoms, Other, specify:

Resident of Correctional Facility at Time of Dx: Yes, No, Unknown, Incarceration Date, 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, Residential Facility, Mental Health Residential Facility, Nursing Home, Alcohol/Drug Treatment Facility, Other Long Term Care Facility

POPULATION RISKS, MEDICAL RISKS, HIV TEST RESULTS, End stage renal disease, Organ Transplant, Other: None of these medical risks apply

TB Skin Test, IGRA, Documented history of positive TST or IGRA?, PRIOR LTBI TREATMENT, Yes, No, Start Date, Stop Date

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

FOR TREATMENT OF LTBI ONLY: DOPT, DOPT Site, Frequency, Regimen Start Date, Stop Date, Weight, Height, Isoniazid, Rifampin, Rifapentine, Prescribed for, months, Maximum refills authorized, General Comments, Physician Signature, Date

CLOSURE: Date, Completion adequate therapy, # months on Rx, # months recommended, Lost to follow-up, Patient chose to stop, Deceased (Cause), Adverse drug reaction, Moved out of state/country to, Provider decision: Pregnant, Non-TB, Other: