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

SAVE PRINT CLEAR

Report of Case and Patient Services

Date reported to health department: _____
Date form completed: _____

☐ Initial Report ☐ Hospital Admission ☐ Address Change ☐ Name Change ☐ Update ☐ Other change

SSN _____ Medicaid or ID #_____ DOB _____ Patient's Tel. # _____

Name _____ _____ _____ _____
(Last) (First) (Middle) (Alias)

Address _____ _____ _____ _____ Within City Limits? ☐ Y ☐ N ☐ UNK
Street APT# City County Zip Code

How was patient first reported to HD? ☐ Contact Investigation ☐ EDN Referral ☐ ELR ☐ Genotyping ☐ Hospital Referral ☐ IJN ☐ Private Provider ☐ Targeted Testing ☐ Vital Statistics ☐ Walk-in ☐ Other (specify): _____

Country of Birth _____ **Date of First U.S. Arrival** _____
Eligible for U.S. Citizenship / Nationality at Birth (regardless of country of birth)? ☐ Y ☐ N ☐ UNK **Preferred Language**_____
Sex at Birth ☐ Male ☐ Female ☐ UNK

Notice of Arrival of Alien with TB Class ☐ A ☐ B1 ☐ B2 ☐ B3

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ UNK
Race (check all): ☐ White ☐ Black or African American ☐ Asian (specify)_____ ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander (specify)_____ ☐ Other Race (specify)_____ ☐ UNK

Occupation and Industry: Has the patient ever worked as one of the following? (Select all that apply)
☐ Healthcare worker ☐ Correctional facility employee ☐ Migrant / seasonal worker ☐ None of the above ☐ UNK
Current Occupation and Industry: _____

Initial Reason Evaluated for TB (select one): ☐ Contact investigation ☐ Screening ☐ TB symptoms ☐ Other_____ ☐ UNK

Case Meets Binational (BN) Reporting Criteria? ☐ Y ☐ N ☐ UNK If Yes, which criteria? (Select all that apply): ☐ Exposure to suspected product from Canada or Mexico ☐ Has case contacts in or from Mexico or Canada ☐ Potentially exposed by a resident of Mexico or Canada ☐ Potentially exposed while in Mexico or Canada ☐ Resident of Canada or Mexico ☐ Other situations that may require BN notification or coordination

Social Risk Factors
Heavy Alcohol Use in the Past 12 Months ☐ Y ☐ N ☐ UNK
Noninjecting Drug Use in the past 12 Months ☐ Y ☐ N ☐ UNK
Homeless Ever ☐ Y ☐ N ☐ UNK
Injecting Drug Use in the Past 12 Months ☐ Y ☐ N ☐ UNK
Homeless in the Past 12 Months ☐ Y ☐ N ☐ UNK
Resident of Correctional Facility Ever ☐ Y ☐ N ☐ UNK

Resident of Correctional Facility at the Time of Diagnostic Evaluation ☐ Y ☐ N ☐ UNK **Incarceration Date**_____
If Yes, ☐ Federal prison ☐ State prison ☐ Local jail ☐ Juvenile correctional facility ☐ Other / UNK

Resident of Long-Term Care Facility at Time of Diagnostic Evaluation ☐ Y ☐ N ☐ UNK If Yes, ☐ Nursing home ☐ Hospital-based facility ☐ Residential facility ☐ Mental health residential facility ☐ Alcohol or drug treatment facility ☐ Other ☐ UNK

Current Smoking Status at Diagnostic Evaluation ☐ Current Everyday ☐ Current Someday ☐ Former ☐ Never ☐ Current Status UNK ☐ UNK

Patient lived outside US for >2 months (uninterrupted): ☐ Y ☐ N ☐ UNK

Medical Risk Factors
Diabetic At Diagnostic Evaluation ☐ Y ☐ N ☐ UNK End-Stage Renal Disease ☐ Y ☐ N ☐ UNK HIV/AIDS ☐ Y ☐ N ☐ UNK
Other Immunocompromised (other than HIV or AIDS) ☐ Y ☐ N ☐ UNK Post Organ Transplantation ☐ Y ☐ N ☐ UNK
TNF-alpha Antagonist Therapy ☐ Y ☐ N ☐ UNK Viral Hepatitis (B or C Only) ☐ Y ☐ N ☐ UNK Cancer - Head and/or Neck ☐ Y ☐ N ☐ UNK
Cancer – Other ☐ Y ☐ N ☐ UNK Chronic Renal disease ☐ Y ☐ N ☐ UNK Hemodialysis ☐ Y ☐ N ☐ UNK
Gastrectomy or Jejunoileal Bypass ☐ Y ☐ N ☐ UNK COVID-19 Co-Infection ☐ Y ☐ N ☐ UNK Silicosis ☐ Y ☐ N ☐ UNK
Skin Test Conversion ≥ 10 mm or more within 2 years ☐ Y ☐ N ☐ UNK Weight 10% < ideal body weight ☐ Y ☐ N ☐ UNK ☐ Other: _____

HIV Test Result
Date Collected _____ Date Reported _____
☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
☐ Refused ☐ Not Offered ☐ Test done, result UNK
☐ Not Done **CD4 Count:** Date _____ Result_____

TB Screening Documented history of positive TST or IGRA? ☐ Y ☐ N ☐ UNK
☐ Tuberculin Skin Test (TST) ☐ IGRA, type: ☐ QFT ☐ TSPOT ☐ UNK ☐ Other
Date Administered/Collected_____ Date Read/Reported _____
Results ☐ Positive; if TST, mm: _____ ☐ Negative ☐ Not Done/Read
☐ Indeterminate ☐ Test done, result UNK ☐ UNK ☐ Refused

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

Previous LTBI Diagnosis ☐ Y ☐ N ☐ UNK
Completed Treatment ☐ Y ☐ N ☐ UNK

Treatment and Outcomes Date of Normal Chest X- Ray _____
Treatment Administration ☐ DOT ☐ EDOT (VDOT) ☐ Self-Administered
Site ☐ Clinic or medical facility ☐ Field **Frequency** ☐ Daily ☐ Once Weekly ☐ Twice Weekly
Treatment Type ☐ Window Prophylaxis ☐ LTBI
Regimen Start Date _____Stop Date_____ Weight_____ Height_____
Regimen Restart Date_____ Stop Date _____Weight_____Height_____

☐ Isoniazid _____mgs ☐ Rifapentine _____mgs ☐ Rifampin _____mgs ☐ B6 _____mgs
Other, specify: _____

Prescribed for: _____Months _____Maximum refills authorized

General Comments:

Physician Signature **Date**

Closure Date _____ #_____ months on Rx #_____ months recommended ☐ Completed Treatment ☐ Lost to follow-up ☐ Patient Choice ☐ Pregnancy ☐ Not LTBI (Clinician Decision) ☐ Developed TB ☐ Severe Adverse Event (☐ Hospitalized ☐ Died) ☐ Other, specify_____