SAVE PRINT CLEAR

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

Report of Case and Patient Services

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

☐Initial Report ☐Drug Resistance ☐Follow-up or Medical Review ☐Hospital Admission or Discharge

Name _____ (Last) _____ (First) _____ (Middle) DOB _____

Address _____ Street ____ APT# _____ City _____ County _____ Zip Code SSN _____

Facility/Care Provider Name: _____ Name of person completing this form: _____

Facility responsible for patient care: ☐Public Health Clinic ☐Private Physician ☐Hospital ☐Other (specify):_____

Signs/Symptoms
☐Fever ☐Weight loss (≥ 10%)
☐Chills ☐Chest pain
☐Cough ☐Shortness of breath
☐Productive cough ☐Lymphadenopathy
☐Hemoptysis ☐Night sweats
☐Other: _____
Date of illness onset: _____

☐Chest X-Ray ☐CT Scan ☐Other:____ Date:_____
☐Consistent with TB ☐Not consistent with TB
☐Not done ☐Unknown
Cavity: ☐Yes ☐No ☐Unknown
Miliary: ☐Yes ☐No ☐Unknown
Status ☐Stable ☐Worsening ☐Improving ☐Unknown
Comments: _____

If Pediatric TB Case (<15 Years Old)
Country of birth for primary guardians: _____
Guardian 1: _____
Guardian 2: _____

Lived Outside US >2 Months (Uninterrupted)
☐Yes, country: _____
☐No
☐Unknown

Status at report ☐New ☐Recurrent ☐Reopen
Prior Therapy ☐Yes ☐No
If yes, 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
☐3 - M. TB Disease, Clinically Active
☐4 - M. TB No Current Disease
☐5 - M. TB Suspect, Diagnosis Pending
Predominant Site (Class 3, 4, 5): _____
Significant Sites (other than Predominant)
☐Pulmonary ☐Bone and/or Joint
☐Pleural ☐Genitourinary
☐Lymphatic (specify) _____ ☐Peritoneal
☐Meningeal ☐Other (specify) _____
☐Laryngeal ☐Site not stated
Other Diagnosis _____

Treatment for Active TB Disease Weight _____ Height _____
Date Therapy Started _____ Date Therapy Stopped _____
Restart _____ Stop _____
Treatment administration: ☐DOT ☐eDOT ☐Self-administered
DOT Site: ☐Clinic/medical facility ☐Field ☐eDOT
Frequency: ☐Daily: 5x/week ☐Daily: 7x/week ☐2x/week ☐3x/week

☐Isoniazid	_____ mgs	☐Bedaquiline	_____ mgs
☐Rifampin	_____ mgs	☐Clofazimine	_____ mgs
☐Pyrazinamide	_____ mgs	☐Cycloserine	_____ mgs
☐Ethambutol	_____ mgs	☐Linezolid	_____ mgs
☐Ethionamide	_____ mgs	☐Pretomanid	_____ mgs
☐Amikacin	_____ mgs	☐Delamanid	_____ mgs
☐Rifabutin	_____ mgs	☐PAS	_____ mgs
☐Levofloxacin	_____ mgs	☐B6	_____ mgs
☐Moxifloxacin	_____ mgs	☐_____	_____ mgs
☐Rifapentine	_____ mgs	☐_____	_____ mgs

If Initial Drug Regimen Not RIPE, why not? _____
Prescribed for: _____ months Maximum refills authorized: _____

Closure Date: _____
☐Completed treatment ☐Lost
☐Patient choice ☐Adverse treatment event
☐Dying ☐Died (cause): _____
☐Not TB ☐Unknown
☐Other
Moved during therapy? ☐Yes ☐No ☐Unknown
If yes, out of state/country? Specify: _____
Transnational referral made? ☐Yes ☐No ☐Unknown
Doses taken: _____ Doses taken by DOT: _____
Doses recommended: _____ % Doses taken by DOT: _____
Months on Rx: _____ Months recommended: _____

AFB Smear Results
Current _____ ☐Negative ☐Positive ☐Indeterminate ☐Not done ☐Unknown
Specimen type: ☐sputum ☐urine ☐bronchial washing ☐biopsy ☐other
If biopsy or other, list anatomic site of specimen _____
If other than sputa, type of exam _____
Collection date of initial positive AFB smear _____
Collection date of first consistently negative AFB smear _____

Nucleic Acid Amplification Test
Current _____ ☐Negative ☐Positive ☐Indeterminate ☐Not done ☐Unknown

Culture Results
Current _____ ☐Negative ☐Pending ☐Not done ☐Unknown
☐Positive for M. TB ☐Non-M. TB (specify): _____
Specimen source site/type: ☐sputum ☐urine ☐bronchial washing ☐biopsy _____ ☐other _____
Date initial specimen collected: _____ Date reported: _____
Collection date of initial positive M. TB culture: _____
Collection date of first consistently negative M. TB culture: _____
Sputum culture conversion documented? ☐Yes ☐No ☐Unknown
If no, specify reason: _____

Susceptibility Results
☐Phenotypic/Growth-Based ☐Genotypic/Molecular
Initial specimen collection date: _____ Resistant to: ☐INH ☐RIF ☐Other
Other resistance: _____
Last pos. culture date: _____ Resistant to: ☐INH ☐RIF ☐Other
Other resistance: _____
Was the Patient Treated as an MDR TB Case (Regardless of DST Results)?
☐Yes ☐No ☐Unknown

Reason Therapy Extending >12 months: _____
Hospitalization Advised: ☐Yes ☐No Control Order: _____
Compliant: ☐Yes ☐No
Quarantine Advised: ☐Yes ☐No Court Action: _____
Isolation: ☐Yes, date: _____ ☐No, date released: _____

General Comments:

_____
Nurse Signature Date

_____
Physician Signature Date

☐Authorize nurse to obtain informed consent