TEXAS
Health and Human Services

Texas Department of State Health Services

Jennifer A. Shuford, M.D., M.P.H.
Commissioner

Dear Colleague,

Over the past 2 years, the CDC has reported a partial rebound in cases of tuberculosis (TB) ending a multi-year trend of decreasing cases nationwide. Tuberculosis is a notifiable condition in Texas and the prompt reporting of suspected and confirmed cases of TB to public health is essential for controlling and preventing the spread of the disease.

The Texas Department of State Health Services, Public Health Region 8 (PHR 8), provides management and treatment to clients with suspected and confirmed TB disease including medication adherence through directly observed therapy, isolation when needed, medication refinement, and treatment to cure. PHR 8 staff also do complex case investigations to identify and screen all close contacts and provide treatment to anyone who has been infected. All these services are provided free-of-charge. We treat the patient, prevent the spread of TB, and protect the public's health.

The Texas Administrative Code (TAC), Title 25, Part 1, Chapter 97, Subchapter A, Rule §97.3, requires suspected and confirmed cases of tuberculosis (Mycobacterium tuberculosis complex) be reported within 1 working day to your local or regional health department.

Reportable tuberculosis disease (confirmed/suspected) includes the following:

- Suspected tuberculosis disease pending final laboratory results (TB symptoms, abnormal CXR/CT)
- Positive nucleic acid amplification tests
- Clinically or laboratory-confirmed tuberculosis disease
- All Mycobacterium tuberculosis (M. tb) complex including M. tuberculosis, M. bovis, M. africanum, M. canettii, M. microti, M. caprae, and M. pinnipedii

If you have a patient with known or suspected TB, please fax the information to the Texas Department of State Health Services (DSHS) PHR 8 within 1 working day:

FAX NUMBER:	**512-206-3949**
PHONE NUMBER:	210-949-2000
ADDRESS:	Texas Department of State Health Services, Region 8 7430 Louis Pasteur San Antonio, TX 78229

For additional information, please see the following websites:
For TB reporting: Texas DSHS TB Program – How to Report Tuberculosis
For disease reporting: IDPS | Notifiable Conditions (state.tx.us)

If you have any questions, please do not hesitate to contact our office.

Sincerely,

Lillian Ringsdorf, MD, MPH
Regional Medical Director
Texas Department of State Health Services, Public Health Region 8

TEXAS Department of State Health Services

Infectious Disease Report

Form is published at
http://www.dshs.state.tx.us/idcu/investigation/conditions/

General Instructions

This form may be used to ***report suspected cases and cases of notifiable conditions*** in Texas, listed with their reporting timeframes on the current *Texas Notifiable Conditions List* available at http://www.dshs.state.tx.us/idcu/investigation/conditions/. In addition to specified reportable conditions, ***any outbreak, exotic disease, or unusual group expression of disease that may be of public health concern should be reported*** *by the most expeditious means available*. A health department epidemiologist may contact you to further investigate this Infectious Disease Report.

Suspected cases and cases should be reported to your local or regional health department.

Contact information for your local or regional health department can be found at:
http://www.dshs.state.tx.us/idcu/investigation/conditions/contacts/

As needed, cases may be reported to the Department of State Health Services by calling 1-800-252-8239.

Disease or Condition	Date: _____ (*Check type*) *(Please fill in onset or closest known date)*	☐ Onset ☐ Specimen collection ☐ Absence ☐ Office visit		
Practitioner Name	Practitioner Address/☐ See Facility address below	Practitioner Phone/☐ See Facility phone below (_____) _____ - _____		
Diagnostic Criteria (Diagnostic Lab Test Type, Result, and Specimen Source if applicable and/or Clinical Indicators)				
Patient: Name (Last)	(First)	(MI)	Phone Number: (____) ____ - _____	
Address (Street)	City	State	Zip Code	County
Date of Birth (mm/dd/yyyy)	Age	Sex ☐ Male ☐ Female ☐ Other _____	Ethnicity ☐ Hispanic ☐ Not Hispanic	Race ☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown

Notes, comments, additional information such as other lab tests/results, clinical info, pregnancy status, occupation (food handler), school name/grade, travel history

Name of Reporting Facility	Address	
Name of Person Reporting	Title	Phone Number (____) _____ - _____ extension _____
Date of Report (mm/dd/yyyy)	E-mail	

Health Department (local, regional, or state) use only

☐ Confirmed ☐ Probable ☐ Suspected ☐ Dropped ☐ Duplicate, with new information

Above Information is CONFIDENTIAL. Please notify sender if received in error and return or destroy.

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

Report of Case and Patient Services

Date reported to health department _____
Date form sent to PHR _____
Date form sent to central office _____

☐ Initial Report ☐ Drug Resistance ☐ Followup or Medical Review ☐ Hospital Admission or Discharge

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

_____ 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 at DX (Check all that apply)
☐ Fever ☐ Weight Loss (≥ 10%)
☐ Chills
☐ Cough ☐ Other: _____
☐ Productive Cough
☐ Hemoptysis
☐ Night Sweat
Date of earliest onset _____

Chest X-Ray ☐ **CT Scan** Date _____
☐ Normal ☐ Abnormal ☐ Not Done ☐ Unknown
If Abnormal, check abnormality
☐ Cavitary
☐ Non-cavitary, consistent with TB
☐ Non-cavitary, not consistent with TB
Status
☐ Stable
☐ Worsening
☐ Improving
☐ Unknown
Comments: _____

If Pediatric TB Case (<15 Years Old)
Country of birth for primary guardians:
Guardian 1: _____
Guardian 2: _____
Patient lived outside US for > 3 months
☐ Yes, country: _____
☐ No ☐ Unknown

Status ☐ 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 Infection, Current Disease
☐ 4 - M. TB, No Current Disease
☐ 5 - M. TB Suspect, Diagnosis Pending
Predominant Site (Class 3, 4, 5): _____

Significant Sites (other than Predominant)
00 ☐ Pulmonary
10 ☐ Pleural
20 ☐ Lymphatic
21 ☐ Cervical
22 ☐ Intrathoracic
23 ☐ Other
30 ☐ Bone and/or Joint
40 ☐ Genitourinary
50 ☐ Miliary/Disseminated
60 ☐ Meningeal
70 ☐ Peritoneal
80 ☐ Other (Specify) _____

Other Diagnosis _____

Treatment for Active TB Disease Weight _____ Height _____
Regimen Start _____ Regimen Stop _____
Restart _____ Stop _____
DOT: ☐ Yes ☐ No, specify reason: _____
DOT Site: ☐ Clinic or other medical facility ☐ Field ☐ VDOT
Frequency: ☐ Daily:5x/week ☐ Daily: 7x/week ☐ 2x/week ☐ 3x/week

☐ Isoniazid	____ mgs	☐ Rifater	____ mgs
☐ Rifampin	____ mgs	☐ Levofloxacin	____ mgs
☐ Rifamate	____ mgs	☐ Moxifloxacin	____ mgs
☐ Pyrazinamide	____ mgs	☐ Rifapentine	____ mgs
☐ Ethambutol	____ mgs	☐ Bedaquiline	____ mgs
☐ Streptomycin	____ mgs	☐ Clofazimine	____ mgs
☐ Ethionamide	____ mgs	☐ Cycloserine	____ mgs
☐ Capreomycin	____ mgs	☐ Linezolid	____ mgs
☐ Amikacin	____ mgs	☐ PAS	____ mgs
☐ Ciprofloxacin	____ mgs	☐ B6	____ mgs
☐ Ofloxacin	____ mgs	☐ _____	____ mgs
☐ Rifabutin	____ mgs	☐ _____	____ mgs

Prescribed for: ____ months Maximum refills authorized: ____

Closure Date: _____
☐ Completion of adequate therapy ☐ Lost to followup
☐ Patient chose to stop ☐ Adverse drug reaction
☐ Deceased (Cause): _____
☐ Moved out of state/country to: _____
Date referral sent to central office: _____
Provider decision: ☐ Pregnant ☐ Non-TB ☐ Other: _____
Doses Taken: _____ Doses taken by DOT: _____
Doses Recommended: _____ % Doses taken by DOT: _____
Months on Rx: _____ Months Recommended: _____

AFB Smear Results
Current _____ ☐ Negative ☐ Positive ☐ Pending ☐ Not done
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

Culture Results
Current _____ ☐ Negative ☐ Pending ☐ Not done
☐ Positive for M.TB ☐ Non-M.TB, specify: _____
Specimen type: ☐ sputum ☐ urine ☐ bronchial washing ☐ biopsy ☐ other
If biopsy or other, list anatomic site of specimen: _____
Collection date of initial positive MTB culture: _____
Collection date of first consistently negative MTB culture: _____
Sputum culture conversion documented? ☐ Yes ☐ No ☐ NA
If no, specify reason: _____

Susceptibility Results ☐ No Resistance
Initial culture collected: _____ Resistant to: ☐ INH ☐ RIF ☐ EMB
Other resistance: _____
Last pos. culture collected: _____ Resistant to: ☐ INH ☐ RIF ☐ EMB
Other resistance: _____

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

TB-400B (4/2020)