Texas Department of Health
Tuberculosis Elimination Division

Report of Case and Patient Services

Date ___/___/___ (MM DD YY)
☐ Initial Report ☐ Followup or Medical Review
☐ Drug Resistance ☐ Hospital Adm. or Disch.

Name _____ (Last) (First) (Middle) ___/___/___ DOB ___-___-___ SSN

_____ Street Apt. # City County Zip Code

HT ___ WT ___ B/P ___ Temp ___ Pulse ___

_____ Name of Public Health Clinic, Private Physician, Hospital or other Facility

SIGNS/SYMPTOMS AT DX

Fever	☐ Y	☐ N
Chills	☐ Y	☐ N
Cough	☐ Y	☐ N
(Productive)	☐ Y	☐ N
Hemoptysis	☐ Y	☐ N
Night Sweats	☐ Y	☐ N
Weight Loss (≥ 10%)	☐ Y	☐ N

Other:

HIV TEST RESULTS

___/___/___ (MM DD YY)

☐ Negative
☐ Positive
☐ Pending
☐ Not Offered
☐ Refused

ANERGY TESTING

___/___/___ (MM DD YY)

☐ Anergic
☐ Not Anergic

BCG

☐ Yes ___/___/___ (MM DD YY)
☐ No

CHEST X-RAY DATE ___/___/___

Results: ☐ Normal ☐ Abnormal ☐ Not Done ☐ UNK

If Abnormal, Abnormality:
☐ Cavitary
☐ Non-cavitary, consistent with TB
☐ Non-cavitary, not consistent with TB

Status: ☐ Stable ☐ Worsening ☐ Improving ☐ UNK

Comments:

TUBERCULIN SKIN TEST History of positive TST? ☐ Yes ☐ No

___/___/___ ___ mm ☐ Positive ☐ Negative ☐ Not read

___/___/___ ___ mm ☐ Positive ☐ Negative ☐ Not read

AFB SMEAR RESULTS

1 Current ___/___/___ ☐ Negative ☐ Positive ☐ Pending ☐ Not Done
2 Specimen type: ☐ sputum ☐ urine ☐ bronchial washing ☐ biopsy ☐ other
If biopsy or other, list anatomic site of specimen: _____
3 Collection date of initial positive AFB smear: ___/___/___
4 Collection date of first consistently negative AFB smear: ___/___/___

Status: ☐ New Case ☐ Recurrent ☐ Reopen
Prior LTBI Treatment ☐ Yes ☐ No Start Date ___/___/___
Prior Therapy ☐ Yes ☐ No Start 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)

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

Significant Sites other than Predominant: _____
Other Diagnosis:

CULTURE RESULTS

1 Current ___/___/___ ☐ Negative ☐ Positive for MTB
☐ Positive for Non-MTB _____ ☐ Pending ☐ Not done
2 Specimen type: ☐ sputum ☐ urine ☐ bronchial washing ☐ biopsy ☐ other
If biopsy or other, list anatomic site of specimen: _____
3 Collection date of initial positive MTB culture: ___/___/___
4 Collection date of first consistently negative MTB culture: ___/___/___
5 Sputum culture conversion documented? ☐ Yes ☐ No ☐ NA

SUSCEPTIBILITY RESULTS

1 Date initial positive culture was collected ___/___/___
2 Initial culture was resistant to: ☐ Isoniazid
☐ Rifampin ☐ Ethambutol ☐ Other _____
3 Date last positive culture was collected ___/___/___
4 Last culture was resistant to: ☐ Isoniazid
☐ Rifampin ☐ Ethambutol ☐ Other _____

TREATMENT

Regimen Start ___/___/___ Regimen Stop ___/___/___
Restart ___/___/___ Stop ___/___/___

DOT: ☐ Yes, totally directly observed ☐ No, self-administered ☐ Both

DOT Site: ☐ Clinic or other medical facility ☐ Field ☐ Both

Frequency: ☐ Daily ☐ Twice Weekly ☐ Three X's Weekly

☐ Isoniazid	___ mgs	☐ Ciprofloxacin	___ mgs
☐ Rifampin	___ mgs	☐ Ofloxacin	___ mgs
☐ Rifamate(INH+RIF)	___ mgs	☐ Rifabutin	___ mgs
☐ Pyrazinamide	___ mgs	☐ Rifater (INH+RIF+PZA)	___ mgs
☐ Ethambutol	___ mgs	☐ Levofloxacin	___ mgs
☐ Streptomycin	___ mgs	☐ _____	___ mgs
☐ Ethionamide	___ mgs	☐ _____	___ mgs
☐ Capreomycin	___ mgs	☐ B_6	___ mgs
☐ Amikacin	___ mgs		

Prescribed for: _____ months Maximum refills authorized: _____

Hospitalization Advised: ☐ Yes ☐ No
Quarantine Advised: ☐ Yes ☐ No*
Control Order ___/___/___
Court Action ___/___/___
Return for chest x-ray: ___/___/___
Collect next sputum on: ___/___/___
Other lab studies: _____
Return to MD clinic on: ___/___/___
Return to Nurse clinic on: ___/___/___
Compliant: ☐ Yes ☐ No

_____ ___/___/___
Nurse Signature Date

_____ ___/___/___
Physician Signature Date

_____ Authorize nurse to obtain informed consent

CLOSURE ___/___/___ (Date)
☐ Completion of adequate therapy _____ # months on Rx _____ # months recommended
☐ Lost to followup
☐ Patient chose to stop
☐ Deceased (Cause) _____
☐ Adverse Drug Reaction
☐ Moved out of state to: _____

Date referral sent to Austin ___/___/___

Provider decision: ☐ Pregnant
☐ Non-TB
☐ Other _____

General Comments:

TB-400B (01/03)