Initial TB Case Report Form

Reporting of all patients with confirmed or suspect tuberculosis (TB) is mandated by the State of California Health and Safety Code. All TB cases and suspects must be reported within one day of diagnosis.

WHY DO YOU REPORT?

The health department performs many vital functions to ensure public health and safety, including case management, contact follow-up, assessment of compliance with treatment and appointments, and directly observed therapy (DOT) per Health and Safety Code 120175. The TB Control staff will also assist in facilitating timely and appropriate hospital discharge planning. Since January 1, 1994, state law mandates that all TB patients have a health department-approved hospital discharge plan, prior to discharge.

WHO MUST REPORT?

Anyone aware of a patient suspected to have, or confirmed with, active TB.

WHEN DO YOU REPORT?

A) When active TB is one of the primary differential diagnoses. This often occurs when:
   1. signs and symptoms of TB are present, and/or
   2. the patient has an abnormal chest x-ray consistent with TB, and/or
   3. the patient is placed on multidrug therapy for active TB or
B) When specimen smears are positive for acid fast bacilli (AFB).
C) When the patient has a positive M. tuberculosis or M. bovis culture.

HOW DO YOU REPORT?

The Initial TB Case Report Form is to be completed in its entirety and submitted to the health department. Include copies of chest x-rays, preliminary AFB lab reports, and clinic notes. TB Control staff will review this form and may return a call to the physician as needed.

By phone: (800) 722-4794 (weekdays 8:00 a.m.-5:00 p.m.)
By pager: (909) 677-7168 (after hours and holidays)
By FAX: (909) 387-6377 (please follow up a fax with a phone call during business hours)

The Initial TB Case Report Form, when submitted to TB Control, fulfills the legal requirement for any outpatient reporting. The process for discharge or transfer approval necessitates a different form. Please call (800) 722-4794 for further information about hospital discharge care plan submission/approval.
Initial TB Case Report Form

PATIENT: ________________________________

Last: ___________________  First: ___________________  MI: ___________________

ADDRESS: __________________________________________________

Phone: ( )  Cell: ( )

BIRTH DATE: __/__/______  SEX □ M  □ F

If patient is under 18, parent’s name______________________________

EMPLOYER/SCHOOL: ________________________________

Phone: ( )

COUNTRY OF ORIGIN: __________________________________________

MONTH/YEAR ARRIVED IN US: ____________________/______

FOREIGN TRAVEL

□ White, non-Hispanic  □ Black  □ AM Ind/Eskimo

□ Hispanic  □ Asian/Pac. Is. (specify) ____________

□ Other________________

REPORTED BY: ________________

PHYSICIAN: ________________________________

PHONE: ( )

INSURANCE/FUNDING: _______________________________________

□ Pulmonary  □ Extrapulmonary (site) _____________________________

Date dx: / / ______

Skin Test: _____ mm  Date: __________

Quantiferon result: neg  pos  Date: __________

Chest X-Ray Date: ______

□ Cavitary  □ Non-Cav.

Impression: ________________________________

If Pulmonary, check symptoms:

□ Cough: Start Date ______

□ Night sweats/Fever

□ Sputum production  □ Hemoptyisis

□ Weight loss (# of lbs.)_______(# of mos.)______  □ Fatigue

If no symptoms, reason for evaluation:

Other medical conditions:

□ HIV: Date ______

□ Positive  □ Negative  □ Recommended

History of TB Treatment

□ Yes  □ No  □ LTBI

If Yes: Where/when treated? ________________________________

Patient’s current weight ______ lbs/kg

Psychosocial History: smoker____ ppd etoh use?______

Drug use? ______ IVDU?

Date/CD4 / ______  Date/VL / ______  Allergies________________

<table>
<thead>
<tr>
<th>SPEC. #</th>
<th>SPEC. DATE</th>
<th>SPEC. TYPE</th>
<th>AFB SMR.</th>
<th>MTD/PCR</th>
<th>AFB CULT</th>
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LAB NAME: ________________________________

PATH REPORT: ________________________________

ADDITIONAL COMMENTS: _______________________________________

DATE REPORTED: ________________  INTAKE STAFF: __________________

Medications

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<tr>
<th>MEDICATIONS</th>
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<td>ISONIAZID</td>
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<td>RIFAMPIN/RBN</td>
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<td>PYRAZINAMIDE</td>
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<td>PYRIDOXINE (B6)</td>
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HAART: ________________________________

Rev. 2.7.17