

**Virginia Department of Health
TB Intake Sheet**

WebVision # _____

Last Name _____ First Name _____ Middle _____
 Birth Date ____ / ____ / ____ Race ____ Sex ____ Marital status ____ Parent/Guardian _____
 Home Address _____ Apt # _____
 City _____ State _____ Zip _____
 Home Phone _____ Work Phone: _____ Cell Phone _____
 Country of Origin _____ Year of arrival _____ Preferred Language _____
 Provider _____ Provider Phone _____
 Reporting Source _____ Reporter Phone _____

TB Symptoms (Check all that apply. May skip section and complete Health History form if from patient interview)
 None
 Cough \geq 3 weeks
 Productive? Y N Hemoptysis? Y N
 Fever, unexplained
 Unexplained weight loss
 Poor appetite
 Night Sweats
 Fatigue

Weight _____ Height _____
 Initial blood work? Yes No Report: Yes No
 LMP _____ EDD _____ BCG Yes No

TST Results
 Date Given _____ Date Read _____
 Induration _____ mm Positive Negative

Current Chest x-ray Date _____
 Location of film: _____ Addl. Old Films: Y N
 Negative Abnormal Cavitory
 Describe: _____

HIV Testing
 Not Tested
 Tested
 Negative
 Positive
 Results pending
 Date _____

Other Info
 Hospitalized: Y N
 Where? _____
 Room # _____

Additional Individual Risk for Infection
 (Check all that apply)
 Identified Contact (Case _____)
 \geq 3 months in high prevalence country
 Resident/employee congregate setting
 Medically underserved
 Uses illegal drugs

Individual Risk for Progression to Disease
 HIV infection
 Medical conditions that increase risk (diabetes, ESRD, Cancer, 10% below ideal weight, etc.)
 History of inadequate TB treatment
 Immunosuppressive therapy (steroids, cancer treatment, include treatment for Rheumatoid Arthritis such as Remicade, Humira, etc.)

Initial Bacteriology (Check for susceptibility if lab not DCLS)

Date	Smear	Culture	Sensitivity

Current Treatment Regimen DOT Self

Drug	Dosage	Frequency	Start Date	Stop Date

Additional Comments (additional treatment information, work site, school, living arrangements, other activities)
 Class B Immigrant/Refugee? Yes A # _____
 Date _____ Completed by _____

Clinician Orders

Isoniazid _____ mg P.O. Qd BIW TIW x _____ doses
 Rifampin _____ mg P.O. Qd BIW TIW x _____ doses
 Pyrazinamide _____ mg P.O. Qd BIW TIW x _____ doses
 Ethambutol _____ mg P.O. Qd BIW TIW x _____ doses
 Pyridoxine _____ mg P.O. Qd BIW TIW x _____ doses
 Meds by DOT
 Sputum collection protocol
 Blood work Specify: _____
 Date _____

Clinician Assessment/Progress Notes
 Clinician Signature _____

TB Intake: