

Complete All Fields

Client Cohort Review Form

Cohort Review Session Date _____ Case Manager _____
 Presented by (person completing form) _____ Health District _____
 VA case #: (On Cohort Review List) _____ Client Initials (first last) _____
 Age _____ Sex (circle): Female Male Medical provider (circle): PMD, LHD or BOTH

Site of Disease **Respiratory (pulmonary, pleural, laryngeal)** _____ **Extrapulmonary** _____

SPUTUM/BACTERIOLOGY Circle all "Yes No or N/A" options below as appropriate
 If respiratory site of disease (*pulmonary, pleural, laryngeal*), was sputa collected? **Yes No N/A**
 If extra-pulmonary site of disease, was sputa collected? **Yes No N/A**
Sputum culture result (circle): **Positive Negative N/A** **Date of Collection** of 1st positive result _____
GeneXpert or other rapid test done (NAA, PCR, MTD)?: **Yes No** Result (circle): **Positive Negative**
Date of Collection of 1st negative sputum culture: _____ **N/A**
Definition: *This culture should have no subsequent positive M. tb cultures and collected at least 1 week after last positive culture.*
 Culture conversion ≤ 60 days from TB Rx start: **Yes No N/A**
Definition: *The number of days from Rx start to date of culture conversion. Indicate if ≤60 days from treatment initiation.*
 If conversion is >60 days after treatment start, provide the dates of the last 3 sputa collected prior to culture conversion.

 Documentation of medical follow-up if no culture conversion in < 60 days? **Yes No**
Culture from site other than sputum **positive for M.tb?**: Site/Source _____ **Date of Collection** _____
CHECK ONE: Culture Diagnosis _____ Clinical Diagnosis _____
 Drug susceptibility results available? **Yes No N/A**
 Was resistance reported? **Yes No** If yes, to which drug(s)? _____

INITIAL TB THERAPY

<i>Drug</i>	<i>Start Date</i>
INH	_____
RIF / rifabutin	_____
EMB	_____
PZA	_____ 8 weeks completed? Yes No

COMPLETION OF TREATMENT

Date of Completion _____
 COT ≤ 366 days? **Yes No N/A** (died, left country)
 If COT > 366 days, why?
 DOT: **Yes No Both**
 If not on DOT, why not?
 # wks planned Rx _____ # of wks Rx completed _____

SECOND LINE DRUGS **Yes No**
 Why added? Resistance _____ Intolerance _____ Other _____

<i>Drug</i>	<i>Start Date</i>
_____	_____
_____	_____
_____	_____
_____	_____

HIV Test must be between 12 months prior to TB evaluation through 8 weeks after treatment start, or HIV + results from any date.
 Documentation of HIV Result Present in Chart:
Yes No Date _____
 Type of documentation?
 If results not present, why not?

CONTACT INVESTIGATION

Was sputum **smear** AFB positive? **Yes No N/A** (i.e. no sputa collected) IF **No** or N/A **STOP** No more info. required.
 If **yes**, were contacts identified? **Yes No** If "yes", how many contacts identified? _____
 Of the contacts identified above, provide the number *completely* evaluated for infection and disease. Include prior positives in this number. _____
Definition: *Completely evaluated includes 1st and 2nd round TST or IGRA, if appropriate by date; CXR if symptomatic or new/first +test for infection; and sputa x 3 if CXR abnormal or symptomatic. Symptom review for those with history +test for infection. Include CXR and medical exam for all children < age 5 or persons with immune suppression.*
 Provide the number of contacts with a **NEW** positive test for TB infection (+TST or IGRA) on the first or second round of testing. Do not include persons subsequently diagnosed with TB disease or those with a history of +test for infection. Do not include persons started on window therapy unless they subsequently test positive for infection. _____
 How many of these with new positive tests for infection started treatment for LTBI? _____
 Of this number, how many with new positive tests for infection completed treatment for LTBI? _____

FOLLOW UP NEEDED (TB Control Use Only)