

Subsequent TB Reports (2013A-TB-003)

Patient Last Name: _____ First: _____ DOB: _____

Updated Contact Information:

Address: _____ Phone: _____

This patient is currently under your care for TB: If not, complete on Section 1 below. If so, skip to Section 2(a).

Section 1

What was the date you last saw the patient? _____

Is the patient's TB currently being treated? Yes No Unknown

If you are no longer the patient's physician, please provide the name and phone number of the patient's current physician, if known:

Name: _____ Phone: _____

Thank you for your assistance!

Section 2(a)

Check here if your patient routinely attends scheduled clinical appointments:

Check here if your patient's progress has been monitored by additional imaging:

If so, latest imaging Date: _____ Finding: Stable Improving Worsening

For TB confirmed by culture, check here if additional bacteriology has been collected:

If so, complete "Latest Bacteriology" below:

Latest Bacteriology Collection Date: _____

Source: Sputum Gastric Aspirate Smear If Positive, Quantity:

Pleural Fluid Urine Spinal Fluid Positive AFB +/- 3+

Lung Tissue Blood Bronchial Washing Negative 1+ 4+

Lymph Node Other: _____ Not Done 2+ Not Reported

Culture: M.tb Mycobacterium Other Than TB Negative Other, specify: If the

latest bacteriology is negative on culture, date of collection of any previous negative culture: Check

here if anti-TB therapy has been completed: Date Completed: _____

If your patient is still on anti-TB therapy, please complete Section 2(b). If not, the form is complete. Thank you for your assistance!

Section 2(b)

Check here if your patient is currently taking anti-TB medications as prescribed: If not, read ** below.

Notes on Patient's Adherence to Treatment:

Current Therapy

<input type="checkbox"/> Isoniazid	Dose/Frequency _____	<input type="checkbox"/> Rifampin	Dose/Frequency _____	<input type="checkbox"/> Rifabutin	Dose/Frequency _____
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<input type="checkbox"/> Pyrazinamide	_____	<input type="checkbox"/> Ethambutol	_____	<input type="checkbox"/> Streptomycin	_____
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Other, specify: _____

What date do you anticipate discontinuing anti-TB medications?

Thank you for your assistance!

** The Virginia Department of Health and the Centers for Disease Control & Prevention recommends directly observed therapy (DOT) as the **Standard of Care** for all patients with pulmonary TB. With DOT, the health department observes TB medication ingestion on a daily or intermittent basis until treatment is completed.

Completed by: _____ Date: _____