

TB Case Closure Report
Fax to TB Control Program
804-371-0248

Date: _____

Name: _____ DOB _____
PHN _____ (phone number _____)

Date Therapy Stopped: _____

Reason Therapy Stopped

- Completed therapy
- Lost
- Uncooperative or refused
- Adverse treatment event
- Not TB
- Died
- Other_ (specify _____)

If died, indicate cause of death (select one) Date of Death: _____

- Related to TB disease
- Related to TB therapy
- Unrelated to TB disease
- Unknown

Reason therapy extended beyond 12 months (select all that apply)

- Rifampin resistant
- Adverse drug reaction
- Non-adherence
- Treatment failure
- Clinically indicated- other reasons
- Other (specify) _____