

**Virginia Department of Health
TB Clinic Record**

Clinic Date _____

Last _____ First _____ Middle _____
 Address _____ City _____ State _____ Zip _____
 Birth Date ____/____/____ VISION # _____ Interpreter _____
 Case Mgr. _____ Case ____ Suspect ____ LTBI/Contact ____

Current Symptoms: _____ None _____ Cough/Sputum ≥ 3 weeks _____ Hemoptysis _____ Fever, unexplained _____ Weight loss/anorexia _____ Wheezing/SOB _____ Night Sweats _____ Fatigue _____ Lymphadenopathy	Weight _____ Height _____ BP _____ Temp _____ LMP _____ EDD _____ Tests: _____ Blood _____ HIV Sputum: ____ Collected ____ Cans given ____ Vision ____ Hearing	See Health History <input type="checkbox"/> Reason for TST: Date _____ Given _____ Date _____ Read _____ Induration ____mm ____ POS ____NEG Past TST Results: HIV ____ Not Tested ____ Negative ____ Positive ____ Results pending
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Reported Side Effects _____ None ____ Loss of appetite _____ Ringing in ears ____ Fatigue _____ Dizziness ____ Nausea/vomiting _____ Numbness ____ Abd. Pain _____ Tingling of extremities ____ Jaundice _____ Joint pains ____ Dark urine _____ Vision/hearing change ____ Rash _____ Behavioral changes ____ Fever _____ Other _____	____ Negative ____ Abnormal ____ Cavitory Describe: _____ Current Chest x-ray _____ Date _____ ____ Negative ____ Abnormal ____ Cavitory Describe: _____	
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Initial Bacteriology				Treatment: <input type="checkbox"/> DOT <input type="checkbox"/> Self				
Date	Smear	Culture	Sensitivity	Drug	Dosage	Frequency	Start Date	Stop Date

Additional Comments:
 Next Clinic date _____
 Next Nurse date _____
 Date _____ Case Mgr. Signature _____

Clinician Assessment/Progress Notes
 Date _____ Clinician Signature _____

Clinician Orders
 _____ Isoniazid _____ mg P.O. [Daily] [Weekly] [Twice Weekly] [Thrice weekly] x _____ doses
 _____ Rifampin _____ mg P.O. [Daily] [Weekly] [Twice Weekly] [Thrice weekly] x _____ doses
 _____ Pyrazinamide _____ mg P.O. [Daily] [Weekly] [Twice Weekly] [Thrice weekly] x _____ doses
 _____ Ethambutol _____ mg P.O. [Daily] [Weekly] [Twice Weekly] [Thrice weekly] x _____ doses
 _____ Pyridoxine _____ mg P.O. [Daily] [Weekly] [Twice Weekly] [Thrice weekly] x _____ doses
 _____ Rifapentine _____ mg P.O. [Daily] [Weekly] [Twice Weekly] [Thrice weekly] x _____ doses
 _____ Meds by DOT
 _____ Sputum collection protocol
 _____ Blood work Specify: _____
 Date _____ Clinician Signature _____

