Tuberculosis Patient Information Sheet: Secondary Report

2001A-TB-002

Patient Last Name: _____ First Name: _____

Address: _____ Occupation: _____

Phone: _____ DOB: _____ Country of Birth: _____ Weight: _____

Race: ☐ White ☐ Asian Hispanic: ☐ Yes Sex: ☐ M ☐ Pregnant

☐ Black ☐ Am. Indian ☐ No ☐ F ☐ History of BCG. Year given: _____

If foreign born, year of entry into U.S.: _____

Date TST Given: _____ Induration: _____ mm or Date of IGRA _____ ☐ Positive ☐ Negative ☐ Prev. Positive

Initial CXR Date: _____ Finding: ☐ Normal If Abnormal: ☐ Cavitary

☐ Abnormal ☐ Non-cavitary

Follow-up CXR Date: _____ Finding: ☐ Stable ☐ Improving ☐ Worsening ☐ Not Done

Bacteriology (Isolate used to rule out or confirm TB) 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

Bacterial confirmation: ☐ Culture ☐ Nucleic Acid Amplification

Laboratory Name: _____

Culture: ☐ M.tb ☐ Non-tuberculous mycobacteria

TB Chemotherapy Start Date: _____ ☐ No medications started

	Dose/Frequency		Dose/Frequency		Dose/Frequency
☐ Isoniazid	_____	☐ Rifampin	_____	☐ Rifabutin	_____
☐ Pyrazinamide	_____	☐ Ethambutol	_____		_____

☐ Other: Specify _____

_____

Drug Susceptibility Testing (M.tb isolates only) ☐ Reported ☐ Not Ordered

If reported, Collection Date of Isolate Tested: _____

Results:

1st Line Drugs	Sensitive	Resistant	Not Done	2nd Line Drugs	Sensitive	Resistant	Not Done
Isoniazid	☐	☐	☐	Capreomycin	☐	☐	☐
Rifampin	☐	☐	☐	Ethionamide	☐	☐	☐
Pyrazinamide	☐	☐	☐	Ofloxacin	☐	☐	☐
Ethambutol	☐	☐	☐	Rifabutin	☐	☐	☐
Streptomycin	☐	☐	☐				

HIV Status: ☐ Positive ☐ Negative ☐ Refused ☐ Indeterminate ☐ Results not shared

☐ Not Offered. Reason: _____

If positive, is patient on anti-viral medication?: ☐ Yes Specify: _____

Household contacts identified and screened? ☐ Yes Provide list of names, addresses and results of screening: _____

_____

_____

Additional Comments: (Concurrent health conditions and medications, etc.)

PMD Info

Name: _____ Address: _____

Phone: _____