Tuberculosis Patient Information Sheet: Subsequent Report 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:			Smear	If Positive, Quantity:	
☐ Pleural Fluid	☐ Urine	☐ Spinal Fluid	☐ Positive AFB	☐ +/-	☐ 3+
☐ Lung Tissue	☐ Blood	☐ Bronchial Washing	☐ Negative	☐ 1+	☐ 4+
☐ Lymph Node	☐ Other: _____		☐ Note Done	☐ 2+	☐ Not Reported

Culture: ☐ M.tb ☐ Nontuberculous mycobacteria ☐ 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

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

☐ 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 recommend directly observed therapy (DOT) as the **Standard of Care** for all patients with TB. With DOT, the health department observes TB medication ingestion on a daily or intermittent basis until treatment is completed.

Completed by: _____ Date: _____