Virginia Department of Health

Recommendations for Tuberculosis Record and Form Use

General

Accurate documentation is an integral part of the treatment and management of all clients served by the Virginia Department of Health (VDH) for a variety of tuberculosis (TB) related diagnoses. Accurate and complete documentation enhances the continuity of care for clients with TB, particularly if different providers are involved in the care over the course of treatment. Appropriate documentation of treatment and its outcome is required for many facets of the TB Program including surveillance and monitoring, assurance and legal enforcement with Virginia's TB Control laws. The TB Program does not use the Document by Exception (DBE) system; therefore, a medical record with thorough and complete documentation must be kept for the assessment, evaluation, management, and treatment of clients with TB related diagnoses.

For all persons served by the TB program, a record of the encounter should be initiated. Individuals reported to the health department as a presumptive or confirmed case of active TB disease, regardless of the source of care, should have a permanent VDH medical record. This record should remain open until the case has a final disposition and be retained according to Library of Virginia policies and procedures for record retention and destruction. A medical record should also be initiated for all individuals referred for chest x-ray and/or recommended for treatment for any TB-related diagnosis. For all clients who do not require a VDH medical record to document an encounter, a TB Risk Assessment (TB 512) form must be completed.

Anytime an interpreter is used, the health department staff shall make a note in the progress notes. Record the date of the visit or call, the name and ID number of the interpreter, and the interpreting service (e.g. Propio, Language Line, etc.) used, if applicable.

The TB Program recommends TB records be set up in a standardized format, utilizing a 6-prong chart. For individuals with TB Infection that decline treatment, a record must be kept, but a 6-prong chart may not be necessary. Refer to the VDH Policy, *Documentation in the Medical Record*, for additional information on documentation. The following recommendations provide additional information on the use of specific forms that have been designed for use in VDH TB records. Please note that electronic, fillable, PDF versions of all of the forms can be found on the TB Program Website: http://www.vdh.virginia.gov/tuberculosis-and-newcomer-health/tuberculosis-new/forms/

Clip 1 – Registration and Consent

This clip in the TB record should house any registration information (registration form, voter registration, eligibility documentation as needed), consents (CHS 1A), and TB agreements (Isolation Instructions, DOT Agreement, VET Agreement).

Isolation Instructions – Complete for any client that needs to be placed in isolation.

- Place a client label in the client label box. In the absence of a label, write in the client's name and date of birth.
- Review instructions thoroughly with the client and/or guardian in the case of a child.

- Obtain signatures from the client and/or guardian, and a witness (this can be the public health nurse or outreach worker). If an interpreter is needed, indicate the name and ID number of the interpreter used.

Directly Observed Therapy (DOT) Agreement – DOT is the standard of care in Virginia to ensure client adherence to treatment of TB disease and shall be used with all clients with presumed or confirmed active TB. DOT may also be used, and is recommended, with TB infection treatment for children under 5 years old, HIV positive individuals, and those taking the 12-week isoniazid/rifapentine treatment regimen. DOT is defined as a healthcare worker, or trained, non-family designee, watching a client ingest and swallow every dose of prescribed medication, making note of any adverse reactions, taking appropriate action if necessary, and documenting the DOT visit.

- Place a client label in the client label box. In the absence of a label, write in the client's name and date of birth.
- Review the agreement thoroughly with the client and/or guardian in the case of a child.
- Fill in each blank on the agreement to arrange DOT details.
- Obtain signatures from the client and/or guardian, and public health nurse. If an interpreter is needed, indicate the name and ID number of the interpreter used.

Video Enhanced Therapy (VET) Agreement – VET is an alternative to DOT for selected clients in Virginia to ensure client adherence to treatment of TB disease. VET is also an alternative for clients receiving the 12-week isoniazid/rifapentine regimen for treatment of TB infection. VET is defined as a healthcare worker, or appropriate trained designee, using live video to watch the client ingest and swallow every dose of prescribed medication, assessing for adverse reactions, taking appropriate action if necessary, and documenting the VET encounter.

- Review the *Recommendations for Video Enhanced Therapy* to verify that the client is eligible for VET prior to completing the VET Agreement. Once all VET criteria are met, the VET Agreement may be completed.
- Place a client label in the client label box. In the absence of a label, write in the client's name and date of birth.
- Review the agreement thoroughly with the client.
- Obtain signatures from the client, and a witness (this can be the public health nurse or outreach worker).

When closing an active TB case record, include the TB Case Completion Report and the Report of Verified Case of Tuberculosis (RVCT) on Clip 1. Central Office may mail the RVCT to the District or, if the District has access, the RVCT can be printed from the Virginia Electronic Disease Surveillance System (VEDSS).

Clip 2 – Medications

VDH Summary of Providers of Care – This is a general VDH form, not specific to TB. Use in all client records to record signatures, titles, and initials of providers documenting in the record. In order to track initials in those parts of the record that allow initials, all providers documenting in the record are to enter their initials, signature and title, and print their name and title using permanent ink.

- Place a client label in the client label box. In the absence of a label, write in the client's name and date of birth.
- This must be completed only once by those providers documenting in the record.
- Enter your initials in the "Initials" column.
- Sign your name and title in the "Signature/Title" column.
- Print your full name and title legibly in the "Printed Name/Title" column.

Medication List – Use in all client records to record all medications the client is taking throughout the course of care.

- Place a client label in the client label box. In the absence of a label, write in the client's name and date of birth.
- Document any known medication allergies in red ink at the top right of the form.
- In the TB Medications table, write the medication name, strength, total dose, route, frequency, start and stop date, as well as the prescriber's name.
- In the Other Medications table, write the medication name, total dose, route, frequency, and start and stop date. Indicate whether the medication is prescription or over the counter, the reason the client reports they are taking the medication, and if there are any interactions with the TB medications.
- Use your provider/clinician approved medication interaction checker (e.g. Drugs.com, Medscape.com). Run the drug interaction check for all medications the client is currently taking. Print the drug interaction report and give to the clinician for review. Check the box under the Other Medications table to indicate that the prescriber was notified of identified drug interactions.
- If additional space is needed for medications, check the Medications continued on the second page box and use the second page to continue writing medications.
- Complete the Prescribers/Clinicians of Care table by writing the name, phone number, and important contact information for all of the clinicians managing the client.
- Items bolded and marked with an asterisk (*) are National Tuberculosis Indicator Project (NTIP) or Virginia indicators.

Prescriptions/Pharmacy Tracking Logs – Any prescriptions or pharmacy tracking logs can be filed here in the TB record. VDH pharmacy tracking logs must be retained according to the pharmacy retention policy, but do not necessarily have to be in the client chart and may be retained in the onsite pharmacy.

Drug Interaction List – Results from your provider/clinician approved drug interaction checker shall include a check of all of the medications the client is currently taking. It shall be kept in the chart and given to the clinician for review.

Directly Observed Therapy (DOT) Log – Use the DOT Log for any client receiving DOT for presumptive/confirmed TB or TB Infection. The current month's DOT Log may be kept in a separate folder for ease of taking to the DOT site. However, as soon as the month is complete, the DOT Log shall be filed in the client record.

- Enter the demographic and case manager information at the top of the log.
- DOT Month: The current month of the year.

- DOT Year: The current year.
- Complete the section listing current medications. Include TB medications the client took on the first date that DOT is given that month. Also note any medications that were stopped or started during the month. All medication changes for the month must be noted.
- DOT Site: Check where the DOT occurred this month. Multiple boxes may be checked.
- Indicate if the health care worker should wear a mask. Once a mask is no longer needed, write in the date the client is no longer infectious.
- DOT Start Date: The very first day DOT was given.
- Each person providing DOT that month should date, print name, sign, and initial.
- Count doses only once all doses were given.
- At the end of the month, calculate the number of weeks of treatment the client received. Use the calculation in the gray column on the right side of the form. If medication administration frequency changed during the month, make additional calculations for each change since the number of weeks of treatment is calculated by dividing the number of doses given by the frequency of administration. For example, if the client received a total of 20 doses in the month at a frequency of 5 times per week, the client would have received 20/5 = 4 weeks of treatment. If the client received 10 doses in the month at 5 times a week and 9 doses at 3 times a week, the client would have received 10/5 = 2 weeks of treatment plus 9/3 = 3 weeks of treatment, for a total of 5 weeks of treatment.
- Check the "Self" box if the client self-administers a dose for any reason. In most instances, these doses should not be counted in the "Dose #" column.
- Check the VET column if Video Enhanced Therapy (VET) is used for DOT.
- Ask the client about side effects at each DOT visit. Check any reported side effect in the appropriate side effect column and write a detailed explanation for the side effect and follow-up in the progress note.
- Obtain client initials whenever possible to increase accountability (not applicable for VET).

Directly Observed Therapy (DOT) Log – 12 Dose Isoniazid-Rifapentine – Use only for clients taking the 12 dose isoniazid-rifapentine regimen for TB infection. This regimen is also referred to as 3HP.

- Place a client label in the client label box. In the absence of a label, write-in the client's name and date of birth.
- Complete the medication table with the medication strength, the total dosage to be given weekly, and the # of tabs to be given weekly.
- Fill-out each column in its entirety each week for the DOT.
- This log does not replace the monthly clinical assessment, which shall be conducted on a monthly basis and documented on the Monthly Clinical Assessment form.
- Print your name, sign, and place your initials on the bottom of the form. If an interpreter is needed, indicate the name and ID number of the interpreter used.

Clip 3 – Assessment

Active TB Case Summary – Use for all presumptive or confirmed active TB client records. This one-page case summary serves as an intake sheet for new cases, captures cohort review data (the NTIP indicators

– which are in bold and marked with an asterisk*), and can be used as a case review form for periodic case reviews.

- Place a client label in the client label box. In the absence of a label, write-in the client's name and date of birth. Add client's address and phone number.
- Report date/source: Enter the date the health department was notified of this client for TB evaluation/follow up, and who reported the client to the health department.
- Site(s) of disease: Enter all sites of TB disease (e.g. pulmonary, laryngeal, abdominal).
- TB Clinician: Enter the provider/clinician(s) who will be managing the TB care for the client.
- Sex: Enter the client's sex.
- Race: Enter the client's race.
- Hispanic or Latino: Circle Y for Yes or N for No.
- Country of origin: Enter the client's country of origin.
- Date arrived: If applicable, enter the date the client arrived in the United States.
- Language(s): Indicate the language(s) the client speaks.
- Interpreter: Circle Y for Yes or N for No to indicate if an interpreter is needed to communicate with the client.
- For children under 15 years old, enter the guardian's country of origin.
- If the client came to the United State with a TB classification, check the appropriate box to indicate the type of TB classification: B0, B1, B2, or B3. Refer to the *Guidance for Evaluating Individuals with Class B TB Conditions* for classification definitions.
- Level of education: enter the client's level of education. This information will help guide your teaching with the client.
- Occupation, Worksite/School name: enter the client's occupation, worksite and/or school name. Use this information to start thinking about a contact investigation.
- Intake TB Symptoms: Place a checkmark in the Y for Yes or N for No column for each TB symptom.
- Social: Place a checkmark in the past and/or present columns next to any social factors that apply to the client. For incarceration and congregate setting, indicate the location.
- General Medical: List any co-morbidities that are relevant to the client's TB diagnosis. Complete medication information will be found on the health history form.
- Other:
    - List the HIV test date and result (for NTIP the HIV test date must be between 12 months prior to TB evaluation through 8 weeks after treatment start).
    - List the Hemoglobin A1c (HgbA1c) result and test date. A HgbA1c should be done on all cases 6 years old and above, unless one was done in the previous 3 months.
    - Document the client's weight at intake and the client's reported usual weight.
- TB History: Indicate if the client has had a positive test for TB infection, any treatment for latent TB infection or active TB disease, and any treatment details.
- Radiology: In the first column, indicate chest x-ray (CXR) or a computerized tomography scan (CT). In the second column, list the date. In the third column write a brief summary of the findings.
- Initial Bacteriology: Enter information about the initial three specimens collected. This could be all sputum samples, but may be a mixture of sputum and other sources. All bacteriology

information should also be listed on the Bacteriology Flow Sheet. This box is intended to give a snapshot of the initial workup. Enter the date, the source of the specimen, if the smear was positive or negative, and if a Nucleic Acid Amplification Test (NAAT) was conducted. Indicate if any resistance was detected on the NAAT, if conducted. A NAAT can also be called a PCR (Polymerase Chain Reaction). PCR is a technology used to run a NAAT; hence, the terms are often used interchangeably. The GeneXpert, used by the state lab (Division of Consolidated Laboratories – DCLS), is a NAAT. Other laboratories have developed their own in-house NAAT and may use this on samples. The benefit of the GeneXpert over an in-house lab NAAT is that it can also detect some strains of Rifampin resistance. A NAAT is done on specimens before there is any growth on liquid or solid media, thus results are received more rapidly (typically within 3-5 days). A NAAT is sometimes mistakenly referred to as a "probe." However, a NAAT should not be confused with a "probe" which is used to detect M.tb in liquid/solid media that has growth.

- Summary Bacteriology:
    - Enter the date of collection for the first sputum that was smear positive or, if not applicable, check the NA box.
    - For sputum smear conversion date, enter the collection date of the first sputum smear negative specimen where no positive sputum smear results followed.
    - Check positive or negative next to sputum culture MTC (*Mycobacterium tuberculosis* complex) to indicate if the client ever had a positive sputum culture.
    - Enter the date of sputum culture conversion and circle Y for yes or N for no to indicate if the culture conversion occurred within 60 days of starting any type of TB therapy. The sputum culture conversion is the collection date of the first sputum sample reported as culture negative, after a previous positive sputum culture for MTC. There can be no MTC positive cultures after this date. If non-tuberculous mycobacteria (NTM) are identified, these specimens are considered culture negative. Do not count contaminated cultures as either positive or negative cultures.
    - In the box with other specimens, indicate if specimens from other sources (apart from sputum) were collected and if they were culture positive for MTC.
    - Circle Y for yes or N for no to indicate if drug sensitivities were conducted and indicate if any resistance was detected.
- Treatment:
    - Complete the table with the TB medications the client has received including their start and stop dates.
    - In the last column, place a check mark next to any medications that had Therapeutic Drug Monitoring (TDM).
    - In the top row of the table circle Y for yes or N for no to indicate if the client started their initial TB therapy with the four main TB medications (isoniazid, rifampin, pyrazinamide, ethambutol).
    - For treatment plan length, enter the number of weeks that the clinician is planning to treat the client.
    - Indicate the last day the client took TB therapy in the date completed box.
- Contact investigation:
    - Check Yes or No to indicate if a contact investigation was conducted. If no, this box is complete. If yes, enter additional information to complete this box.

- Enter the date the contact investigation was initiated (this should be within 1 business day of notification of the case).
- # Identified: Indicate the number of individuals that were identified for the contact investigation that warranted evaluation. Do not include "worried well" or people who may be tested for political reasons.
- # Completed evaluation: Indicate the number of individuals (of those that warranted evaluation) that completed their evaluation.
- # Previous positive contacts: Indicate the number of individuals (of those that warranted evaluation) that were previously positive for TB Infection.
- # New positive contacts: Indicate the number of individuals (of those that warranted evaluation) that were newly identified as positive for TB Infection as a result of the contact investigation.
- # Started LTBI Treatment: Indicate the number of individuals (of those that were newly positive) that started on treatment for Latent TB Infection (LTBI).
- # Completed LTBI Treatment: Indicate the number of individuals (of those that were started on LTBI treatment) that completed treatment for LTBI.
- Note: The Contact Investigation 502 Form with all of the contact's information should be filed in a separate folder that can be stored next to the index case's record but should not be a part of the index case's record. A summary of the contact investigation with aggregate data should be kept in the index case's record.

Initial/Monthly Clinical Assessment – At the onset of treatment and at least once a month, evaluate all clients on treatment with one or more TB medications to check for response to treatment and possible side effects.

- Place a client label in the client label box. In the absence of a label, write-in the client's name and date of birth.
- In the top right, circle if the client is a presumed case, confirmed case, or has TB infection. The same Monthly Clinical Assessment form is used for all clients on treatment with one or more TB medications.
- Fill out each column in its entirety each month for the monthly nursing assessment. Nine columns are provided to allow this form to be used easily for those on isoniazid for 9 months.
- Enter the date at the top of the column that the monthly nursing assessment was completed.
- Enter the treatment month on the next line (2, 3, 4, etc.)
- Enter the weight, and vital signs.
- Listen to lung sounds and indicate whether or not they are clear to auscultation (CTA) at the initial visit.
- Palpate for cervical lymph nodes and document whether or not they are palpable at the initial visit.
- Complete the assessment and review items appropriate for each client. Indicate NA (not applicable) for items when appropriate. Items necessary for monitoring will depend on whether the client is on treatment for active disease or TB infection and the type of medication(s) in use.
- Complete the vision or hearing screening form, if vision or hearing screening is needed.
- For adherence, indicate if the client is doing DOT (documentation of Video Enhanced Therapy (VET) on the DOT record confirms DOT for this form)

- If medication is given during the visit, remember to have the client sign the pharmacy log indicating receipt of the medication. If DOT is conducted, complete DOT Log.
- The nurse case manager completing the assessment should initial at the bottom of the column.
- If completing this form for the initial visit, review the chart to determine whether or not a health history, risk assessment, and medication list were completed.
    - If yes, check the box next to the names of these forms. If the forms were not completed, the PHN should do so at this time.
    - Write in the date and PHN initials upon verifying completion of the above forms.
    - If the risk assessment was not completed, check the appropriate box. (This should only be for Active TB cases.)

TB and Newcomer Health History – Health history information should be gathered and reviewed by the nurse case manager and clinician for all clients. The TB Program and Newcomer Health Program share the same health history form.

- Place a client label in the client label box. In the absence of a label, write-in the client's name and date of birth.
- Indicate with an (X) whether the individual or individual's family member has/had any of the conditions listed.
- Use the "other" box (#36) to indicate the presence of any problem/illness not listed.
- Use the open area to the right under "Office Use Only" to provide specific information about conditions of concern for both the client and family members. Use a progress note if there is not enough space.
- For women, indicate G/P/A status, LMP, estimated date of delivery (if applicable), if she is breast feeding, and record method of birth control.
- Indicate with an (X) if the client has ever been hospitalized. List date(s) and reason(s) why.
- Indicate with an (X) if the client drinks any alcohol, beer, wine, or liquor. Note how much the client drinks.
- Indicate with an (X) if the client uses any cigarette, tobacco, or vaping products. Note how much the client uses. Indicate whether a referral to Quit Now was provided.
- Indicate with an (X) if the client uses other drugs. Note what drug used.
- Indicate with an (X) if the client has any tattoos, body art, body piercings, traditional or tribal scars or markings. Describe any body art etc. that is present.
- Indicate with an (X) if the client is on any TNF Alpha blockers.
- List any medications the client is taking. Complete medication information should be listed on the Medication List.
- Indicate with an (X) if the client uses any traditional herbs or remedies. List what the client uses and how often.
- Indicate the client's current occupation or school.
- Indicate with an (X) the type of residence in which the client lives.
- Indicate the number of people living in the client's home.
- Sign and date the form.

TB Risk Assessment 512 Form – Use to assess and document a client's symptoms and/or TB risk factors. This form is a tool that helps with determining the need for future TB testing and evaluation. It may or may not be in the medical record, depending on the history of entry into care. Refer to the separate Instructions for the *TB Risk Assessment* found on the TB website next to the TB Risk Assessment 512 Form.

Contact Registration Form – Use during a contact investigation to assess and document a contact's symptoms and/or risk factors. This tool can be modified and adapted for each contact investigation by the local health department.

Clip 4 – Notes

It is recommended to insert a tab/page divider between the progress notes and the clinician orders/progress notes.

Progress Notes – Write progress notes for every client, as the TB program does not follow the DBE System. Nurses and outreach workers should document date, and sign every progress note entry. If using the electronic version of the progress note, print the note and sign prior to placing in the chart.

Clinician Orders/Progress Notes – Clinicians use this form to write orders and record notes about clinical assessments and visits with the client. These notes should be kept separately from the nurse and outreach worker progress notes so that orders can be easily located in the record.

Clip 5 – Lab Specimens

The organization of this section in the chart is of utmost importance. It is recommended to insert tabs/page dividers between sections in order to provide organization. Use tabs/page dividers to create the following sections:

- Bacteriology Flow Sheet
- Lab Flow Sheet
- Sputum smears and cultures (bacteriology results)
- Lab work (LFTs, HIV, HgbA1c, IGRA)
- Radiology reports
- Vision monitoring (hearing monitoring if on ototoxic medications)

Bacteriology Flow Sheet – Included in the record anytime sputum or other specimens for bacteriology are collected.

- Place a client label in the client label box. In the absence of a label, write-in the client's name and date of birth.
- 60^{th} day of treatment: Enter the date of the 60^{th} day of treatment for the client. Day 1 is the day the client first takes TB medications. Count every day on the calendar, including weekends to find the 60^{th} day.
- Date of culture conversion: Enter the collection date of the first sputum sample reported as culture negative, after a previous positive sputum culture for MTC. There must be no MTC positive cultures after this date. Non-tuberculous mycobacteria (NTM) identified are considered a negative culture. Contaminated cultures do not count as either positive or negative cultures.

- Complete the tables with all the specimen and result information.
    - Date collected: The date the sample was produced by the client.
    - Specimen type: The source of the sample, i.e. sputum, urine, etc.
    - Specimen number: The number assigned by the Division of Consolidated Laboratory Services (DCLS) or a private laboratory.
    - Smear result: Positive, negative, and/or the amount of acid fast bacilli (AFB) seen.
    - NAAT result: Indicate the result of the Nucleic Acid Amplification Test (NAAT), if done. Indicate if any resistance was detected on the NAAT. A NAAT can also be called a PCR (Polymerase Chain Reaction). PCR is a technology used to run a NAAT; hence the terms are often used interchangeably. The GeneXpert, used by the state lab (DCLS), is a NAAT. Other laboratories have developed their own in-house NAAT and may use this on samples. The benefit of the GeneXpert over an in-house lab NAAT is that it can also detect some strains of Rifampin resistance. A NAAT is done on specimens before there is any growth on liquid or solid media, thus results are received more rapidly (typically within 3-5 days). A NAAT is sometimes mistakenly referred to as a "probe." However, a NAAT should not be confused with a "probe" which is used to detect M.tb in liquid/solid media that has growth.
    - Culture result: Indicate if the culture was negative, or specify the type of organism that grew on culture.
    - Name of lab: The name of the laboratory where the specimen was sent for processing, i.e. DCLS, LabCorp, Quest, etc.
- File original lab reports chronologically in a separate, labeled section of the client record. Group all results for the same specimen together, with the most recent result on the top.
- Most individuals with positive culture results will only have one susceptibility test result. Consider repeat susceptibility testing in cases where the individual remains smear and/or culture positive for a prolonged period of time or converts back to culture positive after having previously converted to culture negative.
- Complete the susceptibility results table with all susceptibility results. If a NAAT that can detect resistance was conducted, write the results in this box (these results will also be listed in the table above).
- Items bolded and marked with an asterisk (*) are National Tuberculosis Indicator Project (NTIP) or Virginia indicators.

Lab Flow Sheet – Use to enter lab results anytime labs are conducted. Allows for monitoring of trends in labs over time and serves as a quick reference for nurse case managers and clinicians reviewing a case.

- Place a client label in the client label box. In the absence of a label, write-in the client's name and date of birth.
- Complete the table in the top right with baseline labs.
    - HgbA1c: List the Hemoglobin A1c (HgbA1c) result and test date. A HgbA1c should be done on all cases 6 years old and above, unless one has been done in the previous 3 months and the result is available.
    - HIV: List the HIV test date and result (for NTIP the HIV test date must be between 12 months prior to TB evaluation through 8 weeks after treatment start).
    - Hepatitis B and C tests may be ordered if the client has risk factors.

    - Pregnancy: For all women of childbearing age, a pregnancy test shall be conducted prior to start of TB medications.
- Complete subsequent tables with lab results that are ordered by clinician(s).
    - Baseline AST, ALT, bilirubin, alkaline phosphate, platelet count, and creatinine are recommended for all cases according to the 2016 Treatment of Drug-Susceptible Tuberculosis practice guidelines.
- Complete bottom table only if any therapeutic drug monitoring (TDM) is conducted on the clients. If conducted, write the name of the medication in the first column and the result in the next available column under the date of the test.
- Items bolded and marked with an asterisk (*) are National Tuberculosis Indicator Project (NTIP) or Virginia indicators.

Vision Monitoring –Evaluate all clients' visual acuity and color perception before starting and while receiving medications that can cause vision changes (ethambutol, linezolid, clofazimine, ethionamide, rifabutin). Use a Snellen chart to assess visual acuity. Use Ishihara test plates to assess color discrimination.

- Place a client label in the client label box. In the absence of a label, write-in the client's name and date of birth.
- Complete the table with baseline screening followed by monthly screenings while the client is taking medications that can cause visual changes.

Hearing Monitoring – Evaluate all clients' hearing and balance before starting and while receiving ototoxic medications (amikacin, capreomycin, streptomycin). Assess auditory function using an audiometer. Assess vestibular function through observation of gait, heel to toe walking, and the Romberg (observation of balance when feet are together, arms down, and eyes closed).

- Place a client label in the client label box. In the absence of a label, write-in the client's name and date of birth.
- Complete the table with baseline screening followed by monthly screenings while the client is taking ototoxic medications.

Clip 6 – External

Used to house external documents and correspondence regarding the client's care.

Electronic Disease Notification (EDN) forms – If the client was a refugee or immigrant with a TB classification, the TB Follow-Up Worksheet from the Electronic Disease Notification system should be located on this clip. If the client had an overseas medical examination, these documents should be filed here in the record.

Correspondence and Miscellaneous – File faxes, letters, emails and any other correspondence with the client and/or the client's providers here in the record.

Medical records from other providers, medical releases, Epi 1, interjurisdictional notifications – File records, releases, and notifications from outside providers here in the record. If the client moves and needs to transfer their TB care, file the interjurisdictional notification documentation here.

Authorization for Disclosure of PHI – This VDH form should be completed and filed here in the record for every client.

TB Treatment/Discharge Plan – This form may or may not be included in the record depending on the client's entry into care. This form shall be filled out for any client that started TB treatment for presumed or confirmed TB while hospitalized and is being discharged on TB medications. The plan is filled out jointly by the hospital and the health department prior to discharge.