TEXAS Health and Human Services | Texas Department of State Health Services

Hansen's Disease Encounter Form
HD 400

This form should be submitted no later than three business days after visit or outreach encounter. Progress notes may be updated when available. Submit via Globalscape and notify HDPCR@dshs.texas.gov.

Visit/Encounter Date:	**Date Submitted**:
Clinic Name:	**Name of Submitter:**

Patient Information			
Last Name:	**First Name:**		**Middle Name:**
DOB:	**SSN:**		**Gender:**
Street Address:			
City:	**Zip:**	**County:**	**State:**
Insurance: Private Medicare/Medicaid None		**Other Insurance:**	
Month/Year Diagnosed:		**Date Last Annual Follow-up:**	

HD Type:	**HD Status:**	**Reactional State:**
Lepromatous (LL) Borderline Lepromatous (BL) Mid-Borderline (BB) Borderline Tuberculoid (BT) Tuberculoid (TT) Indeterminate (I)	Active (A) Observation (OBS) Inactive (IA) Complication (COMP) Suspect (S) Deceased (D) Contact (C) New Case (NC) Lost to Follow-up (LTFU)	Type 1- Reversal Type 2- Erythema Nodosum Leprosum (ENL) Lucio's Phenomenon Uncertain

Initial Biopsy Date:	**Last Biopsy Date:**	**Skin Smear Date:**
Result:	Result:	Result:

Clinic Visit/Outreach Encounter Information				
Physician Name:		**Nurse Name:**		
Height:	**Weight:**	**Temp:**	**BP:**	**Pulse:**
Type of Clinic Visit: Newly diagnosed/first visit Episodic/Unplanned Routine/Planned Annual				

Screens Performed: Hands Feet Eyes

Service(s) Provided:	**Patient Education:**	**Consult/Referral Type:**
Medication Refill Labs Wound Care Behavioral Health Screening Other:	Compliance to Chemotherapy Cause/Transmission Drug Regimen/Toxicity Reaction(s) Care of Hands/Feet/Eyes Acceptance Other:	Ophthalmologist Occupational Therapist Orthotist Physical Therapist Podiatrist Behavioral Health Other: Name of referral site: Reason for Consult/Referral:

Follow-up Outreach Date:

Type of Outreach: Phone Call Text Message Home Visit **Contact Made:** Yes No

Outreach Comments/Notes:

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Medication Information									
Current Medication Protocol: Monthly Rifampin/Moxifloxacin/Minocycline (RMM) Daily Multi-Drug Therapy (MDT) WHO Protocol Prophylaxis Reaction Other:									
Medication Treatment Length: Less than 1 year 1 year Less than 2 years 2 years									
Drug	**Dosage**	**Frequency**	**Start Date**	**Stop Date**	**Reason Stopped**	**Re-start Date**	**Re-stop Date**	**Refill Needed**	**Refill Duration**
Multi-Drug Therapy									
Dapsone									
Rifampin									
Clofazimine									
Clarithromycin									
Minocycline									
Moxifloxacin									
Other:									
Other:									
Reaction Therapy									
Clofazimine									
Methotrexate									
Prednisone									
Thalidomide									
Other:									
Other:									
Other Prescribed Medications									
Treatment Comments:									

Laboratory Tests		
Initial Visit:	**Follow-up Visits:**	**Other Labs (as needed):**
Biopsy: Fite Stain PCR	Biopsy: Fite Stain PCR	BMP
Skin smear CMP	Skin smear	AST
CBC w/diff ESR	CBC w/diff	ALT
CRP G6PD	CMP	Bilirubin
Vit D IGRA	CRP	Alkaline Phos
Hepatitis B* Hepatitis C*	ESR	Eosinophil Count
Other:	Vit D	Other:
	Other:	
*Screen if patient has risk factors and may need Prednisone		

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Progress Notes/Clinic Notes	
PHN Signature:	Date:
Physician Signature:	Date: