SAVE PRINT CLEAR

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

Report of Case and Patient Services

Date reported to health department _____
Date form sent to PHR _____
Date form sent to central office _____

☐ Initial Report ☐ Hospital Admission
☐ Address Change ☐ Name Change (show new name and draw single line through old) ☐ Other Change

SSN _____ Medicaid # _____ ID# _____ DOB _____

Name _____ (Last) _____ (First) _____ (Middle) _____ (Alias)

_____ Street _____ Apt# _____ City _____ County _____ Zip Code _____ Patient's Tel.#

Facility/Care Provider Name _____ Name of person completing this form _____

Initial Reporting Source ☐ Health Dept ☐ Private Physician ☐ Public Hospital ☐ VA Hospital ☐ Military Hospital ☐ TDCJ ☐ Other (Specify): _____

Country of Birth _____
Date of U.S. Entry (if foreign born) _____
Eligible for U.S. Citizenship/ Nationality at Birth? _____
Preferred Language _____

Notice of Arrival of Alien with TB Class
☐ A ☐ B1 ☐ B2 ☐ B3

Reported at Death
☐ Yes ☐ No
Death date _____
Was TB cause of death?
☐ Yes ☐ No ☐ Unk

Reported Out of State or Country
☐ Yes (specify): _____ ☐ No

ETHNICITY ☐ Unknown
☐ Hispanic or Latino
☐ Not Hispanic or Latino

SEX
☐ Male
☐ Female

RACE (check all that apply)
☐ White
☐ Black or African American
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaskan Native
☐ Unknown

OCCUPATION (within past 2 years)
☐ Employed (If employed, check all that apply) ☐ Unemployed during last 2 yrs ☐ Unknown
☐ Health Care Worker (specify): _____
☐ Migrant/Seasonal Worker
☐ Correctional Employee
☐ Other Occupation (specify): _____

Initial Reason Evaluated for TB
☐ Contact Investigation ☐ Screening ☐ TB Symptoms ☐ Other, specify: _____

Resident of Correctional Facility at Time of Dx ☐ Yes ☐ No ☐ Unknown Incarceration Date _____
If Yes ☐ Federal Prison ☐ State Prison ☐ County Jail ☐ City Jail ☐ Juvenile Correctional Facility ☐ ICE ☐ Other

Resident of Long Term Care Facility at Time of Dx ☐ Yes ☐ No ☐ Unknown
If Yes ☐ Nursing Home ☐ Hospital-Based Facility ☐ Residential Facility ☐ Mental Health Residential Facility
☐ Alcohol/Drug Treatment Facility ☐ Other Long Term Care Facility

POPULATION RISKS
☐ Low Income
☐ Inner-city resident
☐ Foreign born
☐ Binational (US-Mexico)
* **Within past 2 years**
☐ Correctional employee*
☐ Health care worker*
☐ Prison/Jail inmate*
☐ Long-term care facility*
☐ Health care facility/resident*
☐ Homeless in past 12 months
☐ Homeless ever
☐ Migrant farm worker*
☐ None of the above risks apply

MEDICAL RISKS
☐ Diabetes mellitus
☐ Alcohol Abuse (within past year)
☐ Tobacco use: _____
☐ Silicosis
☐ Immunosuppressive therapy
☐ TNF-α antagonist therapy
☐ Gastrectomy or jejunoileal bypass
☐ Age ≤ 5 years
☐ Recent exposure to TB (Contact to TB case)
☐ Contact to MDR-TB case
☐ Weight at least 10% less than ideal body weight
☐ Chronic malabsorption syndromes
☐ Leukemia
☐ Lymphoma
☐ Cancer of head
☐ Cancer of neck
☐ Drug abuse within past year:
☐ Injecting
☐ Non-injecting
☐ Unknown if injecting
☐ HIV seropositive (only if laboratory confirmed)
☐ TST/IGRA conversion within 2 years
☐ Fibrotic lesions (on chest x-ray) consistent with old, healed TB
☐ End stage renal disease
☐ Organ Transplant
☐ Other: _____
☐ None of these medical risks apply

HIV TEST RESULTS
Test Date _____
☐ Positive ☐ Negative
☐ Pending ☐ Refused
☐ Not Offered
Date CD4 Count _____
Results CD4 Count _____

☐ **TB Skin Test** ☐ **IGRA** Documented history of positive TST or IGRA? ☐ Yes ☐ No

Date _____ _____ mm ☐ Positive ☐ Negative ☐ Not read/indeterminate/borderline

Date _____ _____ mm ☐ Positive ☐ Negative ☐ Not read/indeterminate/borderline

PRIOR LTBI TREATMENT ☐ Yes ☐ No
Start Date _____
Stop Date _____

ATS Classification
☐ 0 No M. TB Exposure, Not TB Infected
☐ 1 M. TB Exposure, No Evidence of TB Infection
☐ 2 M. TB Infection, No Disease
☐ 4 M. TB, No Current Disease

FOR TREATMENT OF LTBI ONLY

Date Normal Chest X-ray: _____

DOPT: ☐ Yes, totally observed ☐ No, self-administered
DOPT Site: ☐ Clinic or medical facility ☐ Field ☐ VDOT
Frequency: ☐ Daily ☐ Once Weekly ☐ Twice Weekly

Regimen Start Date _____ Stop Date _____ Weight _____
Regimen Restart Date _____ Stop Date _____ Height _____

☐ Isoniazid _____ mgs ☐ B6 _____ mgs
☐ Rifampin _____ mgs ☐ Other (specify): _____ _____ mgs
☐ Rifapentine _____ mgs Prescribed for: _____ months Maximum refills authorized: _____

General Comments:

_____
Physician Signature Date

CLOSURE: Date _____
☐ Lost to follow-up ☐ Patient chose to stop
☐ Adverse drug reaction
Provider decision: ☐ Pregnant ☐ Non-TB
☐ Completion adequate therapy ____ # months on Rx ____ # months recommended
☐ Deceased (Cause): _____
☐ Moved out of state/country to: _____
☐ Other: _____