CONFIRMED/SUSPECTED REPORT OF TUBERCULOSIS DISEASE

Montana Department of Public Health & Human Services
TB Program, Cogswell Building, Room C-216
1400 Broadway, Helena, MT, 59620
Phone: 406-444-0275; Fax: 406-444-0272

Today's Date: ______________________
Submitted By: ______________________

Phone: ______________________

Patient Name: ______________________ Age: _____ DOB: ______________
City: ______________ County: ______________ State: _____ Zip Code: __________
Country of Origin: ______________ If not USA, month & year of Immigration: __________

Gender: ( ) Female ( ) Male
Race: ( ) White ( ) Native American ( ) Other, specify: __________
Ethnic Origin: ( ) Hispanic ( ) Non-Hispanic

Diagnosis Date: ______________________ Date first suspected: ______________
Site: ( ) Pulmonary ( ) Bone/Joint ( ) Lymph ( ) Miliary ( ) GU ( ) Pleural ( ) Other __________
Re-disease after 12+ months of inactivity: ( ) Yes ( ) No List year of previous diagnosis: __________
Diagnosis reported at time of death: ( ) Yes ( ) No Date expired: __________
Contact of known TB case: ( ) Yes ( ) No Name of case: __________

1. Tuberculin Skin Test Results: Date: __________ mm of Induration: __________
2. X-Ray Results: Date: __________ Results: __________
   Attach X-ray results
3. HIV Results: Date: __________ Results: __________

4. Bacteriological Results: **If state lab is not used, attach lab results. If state lab is used, results are on file at the TB program**.

Initial Medication Regime: ( ) INH ( ) Rifampin ( ) Pyrazinamide ( ) Ethambutol ( ) Other __________
Date Therapy Started: __________ **DOT Plan**: (dose, freq, location) ______________________
____
____

Brief Clinical History: ______________________________________
____
____

Resident of Correctional Facility: ( ) Yes ( ) No Facility Name: __________
Resident of Long-term Care Facility: ( ) Yes ( ) No Facility Name: __________
Homeless within the last year: ( ) Yes ( ) No Shelter Name: __________
Occupation: Check all that apply within the past 24 months
( ) Health Care Worker ( ) Migratory Agricultural Worker ( ) Unknown
( ) Correctional Worker ( ) Not employed past 24 months ( ) Other specify: __________

Injecting Drug use within Past Year: ( ) Yes ( ) No ( ) Unknown
Non-injecting Drug use within Past Year: ( ) Yes ( ) No ( ) Unknown
Excess Alcohol Use within Past Year: ( ) Yes ( ) No ( ) Unknown

Liver Disease: ( ) Yes ( ) No ( ) Unknown ( ) Hepatitis A, B, or C Type: __________
Diabetes: ( ) Yes ( ) No ( ) Unknown ( ) Type I ( ) Type II
Organ Transplant: ( ) Yes ( ) No ( ) Unknown Transplant Date: ______ Type: __________

Attending Physician: ______________________ Phone: __________

Public Health Case Manager: ______________________ Phone: __________

TB DIAGNOSTIC REFERRAL FORM:
Active TB Disease or Latent TB Infection (LTBI) ONLY

Today's Date ____________________

Agency ______________________________ Contact __________________________

Address ______________________________ Title __________________________

Phone/Fax_____________________________ Phone __________________________

Patient Name ____

Address ________________________________ City ______________________________

DOB ____________________ Sex ____________ Race ____________________________

Attending Physician ________________________ Phone __________________________

Public Health Manager _______________________ Phone __________________________

This person is being referred because he/she had a Positive Tuberculin/TST Result:

Date ________ Induration in mm ________

Reason for TST/Mantoux:
- ( ) Contact of known TB case
- ( ) Foreign born; Country of origin ______________________
- ( ) Occupational ____________________________________
- ( ) Other ____

FURTHER DIAGNOSTIC TESTS REQUIRED: (Core Curriculum; 4th Edition, 2000)

A complete medical evaluation for TB includes*:* ***1.*** **Tuberculin/TST skin test; 2. Chest X-ray; 3. Medical history; 4. Physical examination; and 5 .Bacteriological or histologic exam if needed based on symptoms and chest X-ray**

Chest X-ray
Date ____________
Results ____
Previous X-ray dates & results ____________________________

Symptoms
( ) Productive, prolonged cough ( ) Chest pain ( ) Hemoptysis
( ) Weight loss ( ) Appetite loss ( ) Tires easily ( ) Night sweats
( ) Fever ( ) Chills

Physical Exam
____
____
____

Risk Factors For Treatment
Liver Disease ( )Yes ( )No ( ) Hepatitis A, B or C Type ____
Diabetes ( )Yes ( ) No ( )Type I ( )Type II
Organ Transplant ( )Yes ( )No Date _________ Type ______
Injecting Drug Use within the past year ( )Yes ( )No
Non-Injecting Drug Use within past year ( )Yes ( )No
Excess Alcohol Use within past year ( )Yes ( )No
Other Comments: ____

Diagnosis ( ) Presumptive/Active TB - **notify your local health department ASAP**

( ) Latent TB Infection (LTBI), Active TB Disease ruled out.

*Treatment LTBI ____

* Until Active TB disease is completely ruled out, DO NOT start patient on medications for treatment for Latent TB Infection (LTBI).

Treatment recommendations for Latent TB Infection: **1.** A 9-month regimen of INH is considered optimal for both HIV-positive and HIV-negative adults; **2.** A 6-month regimen may also provide sufficient protection. **3.** Pyridoxine (Vit B6) is often given to reduce the incidence of INH induced peripheral neuropathy when INH doses exceed 5mg/kg or the patient has HIV, diabetes, alcoholism, malnutrition, pregnant, seizures. ***Core Curriculum on TB, 4th Edition, 2000.*** http://www.cdc.gov/nchstp/tb/pubs;slidesets/core/html/trans6_slides.htm

Monitoring Protocol

1. Baseline liver panel for patients with HIV, alcoholism, history of liver disorder, risk for liver disorder, pregnant and immediate postpartum
2. Monthly follow-up to evaluate adherence and signs & symptoms of active disease
3. Weekly to monthly (depending on meds) follow-up to evaluate for signs & symptoms of hepatitis

Physician ____________________________________ Phone ______________________________

Your Local Health Department offers the following services for patients with Active TB Disease and Latent TB Infection (LTBI):*

1. Help obtaining anti TB medications
2. Regular monitoring of patient adherence
3. Regular monitoring of patient's for changing signs and symptoms of TB
4. Regular monitoring of adverse reactions to anti TB medications
5. Regular communication with prescribing physician

*If you are referring this patient to the health department for treatment monitoring please send the original Rx for INH and Pyridoxine (if prescribed) to your local health department or with the patient.

Please return this form to the ____

(Local health department name & contact person)

Bacteriology Data Sheet

Patient Name ____

Lab Number	Submitted By	Date Collected	Date Received	**AFB Smear Results**	Date Reported	**Culture Results**	Date Reported	**NAA Results**	Date Reported

Susceptibility Results:

Date		INH	S / R
Date		RIF	S / R
Date		EMB	S / R
Date		PZA	S / R
Date		STREP	S / R
Date			S / R

BIOCHEMISTRY DATA

Patient name: ____

DATE									
WBC									
RBC									
HGB									
PLT									
AST									
ALT									
TBIL									
DBIL									
ALKPHOS									
ALBUM									
Serum Drug Levels									
INH									
RIF									
EMB									
PZA									

DATE									
WBC									
RBC									
HGB									
PLT									
AST									
ALT									
TBIL									
DBIL									
ALKPHOS									
ALBUM									
Serum Drug Levels									
INH									
RIF									
EMB									
PZA									

TB HOME EVALUATION

Home Environment

Client has own room: ☐ Yes ☐ No # bedrooms/comments: ______________________________________

Residence: ☐House ☐Apt/Condo ☐Mobile home ☐Motel/Hotel ☐ Shelter ☐ Institution ☐Other/Homeless

Housing Assistance: Section VIII ☐ Yes ☐No *or* HUD ☐ Yes ☐No

in dwelling: Adults___ Children___ . Among them, Immunosupressed**:** ☐ Yes ☐No Who _____________

Adequate food resources: ☐ Yes ☐No Adequate ventilation and heating: ☐ Yes ☐No

Safe place for storing medication: ☐ Yes ☐No

Home safety/ adaptive equipment: ☐ Yes ☐No Specify __________________________________

Pets ☐ Yes ☐No

Assessment/Comments: ____

____

Understanding of Disease

Education: ☐ < High School ☐High School ☐College ☐College +

Drug/Alcohol Risk Factors: ☐ Yes ☐No ☐ N/A, *if yes*, willing to seek TX ☐ Yes ☐No

Adequate knowledge of tuberculosis transmission: ☐ Yes ☐No

Medications:

Adequate understanding of medication side effects: ☐ Yes ☐No

Adequate understanding of medication schedule: ☐ Yes ☐No

Possible drug interaction:____

Treatment Plan:

Understands need to keep doctor/clinic appointments: ☐ Yes ☐No

Understands need to comply with requests for CXR/Lab/ DOT: ☐ Yes ☐No

Assessment/Comments: ____

Social Interaction

Adequate culturally appropriate social support system: ☐ Yes ☐No If Yes, Whom:____________________

Lifestyle consistent with treatment adherence: ☐ Yes ☐No Language limitations: ☐ Yes ☐No

Assessment/Comments: ____

Transportation

Client has a car: ☐ Yes ☐No Relative/Friend will transport? ☐ Yes ☐No

Client needs transportation: ☐ Yes ☐No Client has access to bus service: ☐ Yes ☐No

Knowledge of transportation assistance: ☐ Yes ☐No Client will need bus incentive: ☐ Yes ☐No

Assessment/Comments: ____

____

Financial

Source of income: ___ Other sources: ☐Food Bank ☐Medicare ☐Food Stamps ☐WIC ☐ SSI

☐Other (Specify): ____

Assessment/Comments: ____

____

Date: ____________________ Signature: ____

Copy on your letterhead

Date: ______________

To: Postmaster
____________________, Oregon___________

Address Information Request

Please furnish this agency with the new address, if available, for the following individual or verify whether or not the address given below is one at which mail for this individual is currently being delivered. *If the following address is a post office box, please furnish the street address as recorded on the boxholder's application form.*

Name: ____

Last known address: ____

____

I certify that the address information for this individual is required for the performance of this agency's official duties.

____________________________________	____________________________________
Name	Title

FOR POST OFFICE USE ONLY

( ) Mail is delivered to address given
( ) Not known at address given
( ) Moved, left no forwarding address
( ) No such address
( ) Other (specify):

Agency's Return Address:
as per letterhead

New Address

____

____

Boxholder's Street Address:

____
____

____
Postmark/Date Stamp