

# Tuberculosis Suspect/Case Report

Department of Health  
Tuberculosis Control Program

DATE OF REPORT		
Month	Day	Year

100 Main Street  
City, State 99999  
Tel.# (999) 123-4567

HEALTH DEPARTMENT ONLY CASE NUMBER							
<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15%;"></td> </tr> </table>							

NAME LAST	FIRST	A.K.A	PATIENT'S TELEPHONE NO. ( )	PT'S MEDICAL RECORD NUMBER
STREET:		APT	COUNTY	ZIP CODE
EMPLOYED BY			TELEPHONE NO ( )	
DATE OF BIRTH Month Day Year	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RACE <input type="checkbox"/> WHITE <input type="checkbox"/> AMERICAN INDIAN OR ALASKAN NATIVE <input type="checkbox"/> BLACK <input type="checkbox"/> ASIAN OR PACIFIC ISLANDER		ETHNICITY <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON HISPANIC
SOCIAL SECURITY NO		MEDICAID #	MOTHER'S MAIDEN NAME	
TUBERCULOSIS DIAGNOSIS: Check all disease sites. <input type="checkbox"/> PULMONARY <input type="checkbox"/> GENITOURINARY <input type="checkbox"/> LYMPHATIC <input type="checkbox"/> BONE AND/OR JOINT <input type="checkbox"/> MENINGEAL <input type="checkbox"/> PERITONEAL <input type="checkbox"/> PLEURAL <input type="checkbox"/> MILIARY <input type="checkbox"/> OTHER (SPECIFY) _____				
BACTERIOLOGY: (Please provide the laboratory finding on which diagnosis is based)			DATE SPECIMEN COLLECTED: ____/____/____	
NAME OF LABORATORY: _____				
SOURCE OF SPECIMEN: <input type="checkbox"/> SPUTUM <input type="checkbox"/> OTHER PHYSIOLOGICAL FLUID <input type="checkbox"/> TISSUE TYPE _____		SMEAR <input type="checkbox"/> POSITIVE <input type="checkbox"/> NOT DONE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> PENDING	CULTURE <input type="checkbox"/> POSITIVE MTB <input type="checkbox"/> NOT DONE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> CONTAMINATED <input type="checkbox"/> PENDING <input type="checkbox"/> OTHER _____	
CHEST X-RAY: DATE: ____/____/____ <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL CAVITARY <input type="checkbox"/> ABNORMAL NON-CAVITARY CONSISTENT WITH TB <input type="checkbox"/> ABNORMAL NON-CAVITARY NOT CONSISTENT WITH TB <input type="checkbox"/> NOT DONE <input type="checkbox"/> UNKNOWN		SKIN TEST: DATE: _____ <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> NOT DONE <input type="checkbox"/> UNKNOWN <input type="checkbox"/> MANTOUX _____mm ANERGIC: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		
HOSPITALIZATION: Is patient presently hospitalized? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE ADMITTED: ____/____/____ HOSPITAL & CITY: _____				
DRUG THERAPY STATUS: <input type="checkbox"/> NOT ON ANTI-TB DRUGS (Why?) _____ <input type="checkbox"/> ON ANTI-TB DRUGS SINCE (Date?): ____/____/____ IS PATIENT AWARE OF TB STATUS <input type="checkbox"/> YES <input type="checkbox"/> NO IS PATIENT ALIVE <input type="checkbox"/> YES <input type="checkbox"/> NO IF NOT, DATE OF DEATH ____/____/____		DRUG AND TOTAL DAILY DOSAGE: ISONIAZID (INH) _____(mg) ETHIONAMIDE _____(mg) RIFAMPIN (RIF) _____(mg) CYCLOSERINE _____(mg) PYRAZINAMIDE (PZA) _____(mg) PAS _____(mg) ETHAMBUTOL (EMB) _____(mg) CIPROFLOXACIN _____(mg) STREPTOMYCIN _____(mg) OFLOXACIN _____(mg) KANAMYCIN _____(mg) RIFABUTINE _____(mg) AMIKACIN _____(mg) CLOFAZIMINE _____(mg) CAPREOMYCIN _____(mg) OTHER _____(mg)		
CONDITIONS THAT WOULD AFFECT TB TREATMENT: <input type="checkbox"/> HIV + <input type="checkbox"/> HOMELESS <input type="checkbox"/> OTHER RISK FACTORS _____ WILL TB TREATMENT BE CONTINUED IN YOUR FACILITY AFTER DISCHARGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, WHERE WILL TREATMENT BE GIVEN _____ FACILITY: _____ ADDRESS: _____ TELEPHONE NO: _____				
DOES PATIENT HAVE PAST HISTORY OF TB? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE DIAGNOSED (Mo/Yr) ____/____/____ TB DRUGS USED: _____ WHERE DIAGNOSED _____				
TYPE OF REPORT: <input type="checkbox"/> HOSPITAL <input type="checkbox"/> DOH CLINIC <input type="checkbox"/> PRIVATE PHYSICIAN <input type="checkbox"/> LOCAL HEALTH UNIT <input type="checkbox"/> OTHER (Specify) _____ REPORTED BY: _____ TITLE: _____ TELEPHONE NO: _____ ADDRESS: _____ FOR ADDITIONAL INFORMATION ON THE PATIENT: CONTACT ABOVE/OR NAME: _____ ADDRESS: _____ TELEPHONE NO: _____				

Figure 8.9 Sample of a medical records abstract form; adapted from New York City reporting form.