



TB Medical Report and Treatment Plan

(As required by s. 392.64, F.S.)

Patient Name: _____

ID#: _____

Dr. _____

RETURN COMPLETED FORM TO:

Please complete the information requested on your patient and return this form by:

CHD

Date of Birth: _____

SSN: _____

Address: _____

Attention: _____

Race: _____ Sex: M F Wt.: _____

Telephone #: _____

Allergies: _____

Date Form Completed: _____

Fax #: _____

TB MEDICAL REPORT

TREATMENT PLAN

Client Classification (update as necessary)

Suspect New TB Case

Prior Treatment for TB? Yes No

Medication (dose & interval)

Date started: _____

Date stopped: _____

Location of Disease (Check all that apply)

Pulmonary Pleural Genitourinary

Miliary Meningeal Peritoneal

Bone/joint (Specify) _____

Lymphatic (Specify) _____

Other (Specify) _____

Rifampin

Isoniazid (INH)

Pyrazinamide (PZA)

Ethambutol (EMB)

Pyridoxine (Vitamin B-6)

All other TB and Non-TB Medications (specify or attach)

HIV Status

Date HIV Test Performed: _____

Positive: CD4/VL _____ / _____ Negative Unknown Not done

Clinical Symptoms of TB

Prior to treatment Yes No

Improving with TB Tx Yes No Unk

Expected date of treatment completion: / /

Miscellaneous Information

Is the patient adherent with medication? Yes No

Is the patient keeping appointments? Yes No

When is patient's next appointment? _____

Is the patient lost to follow-up? Yes No

Mantoux Skin Test or IGRA Results

Not done Date _____ Results _____

Mantoux (PPD) _____ mm

IGRA (T-Spot or QFT) _____ Pos Neg

History of BCG: Yes No Unk

Services Available From County Health Department (Check services you want Health Department to provide.)

Sputum exams

Susceptibility testing

Chest x-rays

SGOT/LFTs

Vision Screening

Hearing Screening

Physician - patient visit

TB medications *

Directly observed therapy(DOT)

HIV counseling/testing

Patient education (Specify)

Total care (Includes all of the above)

Other (Specify)

None

(*A new prescription is needed at least every 3 months)

***Note: A source/contact investigation will be conducted by the county health department as appropriate.**

Person to contact in your office for further information.

Phone #: _____

This form will be sent to you for updating at 3 month or more frequent intervals, if indicated.

Chest X-Ray Findings (Complete below or include copies of reports)

Date of x-ray: _____ **Check all that apply:**

Initial Normal

Subsequent Abnormal

If abnormal: (Check all that apply)

Cavitary Noncavitary

Stable Improving Worsening

Bacteriology (Check all that apply or include copies of lab reports)

Date: _____ Specimen type: Sputum Other: _____

Result: AFB+ AFB - Contaminated:

NAAT: MTD/RTPCR: (Specify) _____ Positive Negative

HAINS Test Mutations: katG rpoG inhA None

GeneXpert: M.tb present: Rifampin resistance present:

Culture: M.tb. NTM-Specify: Contaminated:

Were drug susceptibilities done? Yes No

If resistance, list drugs:

Date: _____ Specimen type: Sputum Other: _____

Result: AFB+ AFB - Contaminated:

Culture: M.tb. Negative Contaminated:

Date: _____ Specimen type: Sputum Other: _____

Result: AFB + AFB - Contaminated:

Culture: M.tb.+ Negative Contaminated:

First Consecutive Negative Culture Date: _____

Laboratory Values (or include copies of reports)

WBC ___ HCT ___ PLT ___ BUN ___ Cr ___ AST ___ ALT ___ T-Bili ___

Clinician's Signature/Date