TB Reporting Form for Correctional and Detention Facilities

Name of person completing this form: _____ **Date**: _____

**The Florida Department of Health must be notified via phone or fax within one business day of identifying a new TB suspect or case in accordance with Chapter 64D-3.0029 F.A.C. Supporting documentation & treatment plan must be faxed within 72 hours of the original notification to the FDOH TB Control Section in accordance with Chapter 64D-3.043 F.A.C. See page 4 for fax information.*

◯ TB Suspect ◯ TB Case Site of suspected or confirmed disease: ☐ Pulmonary ☐ Extrapulmonary _____

Primary reason for report

☐ Abnormal chest x-ray ☐ AFB+ smear or culture ☐ TB Symptoms ☐ Other: _____

Client Demographics

Patient Last Name: _____ **First Name**: _____ **Middle**: _____

Inmate # _____ **DOB**: _____ **Social Security Number**:_____ **Gender**: ◯ M ◯ F

Race(s) Select ***all*** that apply:

☐American Indian or Alaskan Native ☐ Asian; optional, specify: _____ ☐White

☐ Black/African American ☐Native Hawaiian or Pacific Islander; optional, specify: _____

Ethnicity: ◯ Non-Hispanic ◯ Hispanic

Client Address

Date Arrived at Current Facility: _____**Current Facility Name**: _____

Street address: _____

Zip: _____ City: _____ County: _____

Telephone: _____ Contact Person: _____

***Was the patient homeless at any time during the 12 months prior to this report?** ◯ Yes ◯ No

Previous Facility Name (if applicable): _____Dates:_____

Street address: _____

Zip: _____ City: _____ County: _____

Telephone: _____ Contact Person: _____

Home Street Address: _____

Zip: _____ City: _____ County: _____

Client Name: _____ DOB: _____

Extended Demographics

Country of Birth: _____ **If not US, Date Arrived in US***: _____
* This date may be precise, i.e. month/day/year; or imprecise, i.e. month/year or year.

Employment History

Was the patient employed during the 24 months prior to this report? ◯ **Yes** ◯ **No**

***If yes, please select the occupation(s) held during the 24 months prior to this report:**

◯ **Correctional employee** ◯ **Health care worker** ◯ **Migratory agricultural worker** ◯ **Other:** _____

Assessment

Date of Assessment: _____

Symptoms and Duration:

Cough for more than 2 wks	◯ Yes ◯ No	
Weight loss	◯ Yes ◯ No	
Night sweats (over 2 wks)	◯ Yes ◯ No	
Fever for more than week	◯ Yes ◯ No	
Hoarseness (over 3 wks)	◯ Yes ◯ No	
Hemoptysis	◯ Yes ◯ No	
Other (specify)	◯ Yes ◯ No	Specify: _____

TB Risk Factors (check all that apply):
☐ Recent arrival from high TB prevalence country; ☐ Renal failure; ☐ Cancer (head/neck/lung); ☐ Organ transplant;
☐ Diabetes mellitus; ☐ Immunosuppressive Meds (e.g., steroids); ☐ Silicosis; ☐ Gastrectomy; ☐ IV drug use
☐ History of recent exposure (within previous 2 years) ☐ History of inadequate treatment for LTBI or TB disease
☐ Other (specify)_____

Prior history of latent (LTBI) or active TB disease diagnosis? ◯ LTBI ◯ TB ◯ No ◯ Unknown

If yes, date of previous diagnosis: _____ Date of final disposition: _____

Was treatment completed? ◯ Yes ◯ No If no, state reason: _____

If yes, did the patient have more than one previous diagnosis? ◯ Yes ◯ No ◯ Unknown

Excess alcohol use within the past year? ◯ Yes ◯ No ◯ Unknown

Injecting drug use within the past year? ◯ Yes ◯ No ◯ Unknown

Non-Injecting drug use within the past year? ◯ Yes ◯ No ◯ Unknown

Infectious Period (date): _____ **to (date):** _____

**Infectious period is for sputum NAA (+) or culture (+) only. Please review pages 6-7 of the CDC guidelines to determine the infectious period using the following link. http://www.cdc.gov/mmwr/pdf/rr/rr5415.pdf*

Most Recent Tuberculin Skin Test (TST) or InterFERON Gamma Release Assay (IGRA):

Date Placed: _____ **Date Read**: _____ **MM of Induration**: _____ **Interpretation** ◯ Positive ◯ Negative
*TST results must be recorded in MM of induration. If this is not documented, please administer the test again unless a severe reaction was reported.
IGRA (QuantiFERON or T-Spot) date: _____ ◯ Positive ◯ Negative ◯ Other: _____

Radiological Exam **- Please attach all Chest Radiological Reports.**

Date of Exam: _____ **Type of Exam**: ☐ X-Ray ☐ CT scan ☐ other: _____

Date of Findings/Interpretation: _____ **Results**: ◯ Abnormal ◯ Normal ◯ Unknown

Cavitation: ◯ Cavitary ◯ Non-Cavitary Consistent with TB ◯ Non-Cavitary Not Consistent with TB ◯ Unknown

Stability: ◯ Improving ◯ Stable ◯ Worsening ◯ Unknown **Only applicable if exam was repeated for comparison*

Notes: _____

HIV Testing

HIV Status Date: _____

HIV Status: ◯ Negative ◯ Positive* ◯ Indeterminate ◯ Refused ◯ Not Offered

***If Positive, Result Verification**: ☐ Medical Documentation ☐ Patient History ☐ Unknown

Labs **- Please attach preliminary or final results (whichever is available).**

NAA Results (RT-PCR or MTD): ◯ Positive ◯ Negative ◯ Not Done ◯ Unknown

Sputum Smear Results: ◯ Positive ◯ Negative ◯ Not Done

Sputum Culture Results: ◯ Positive ◯ Negative ◯ Not Done ◯ Pending

Microscopic Exam of Tissue/Other Body Fluids: ◯ Positive* ◯ Negative ◯ Not Done ◯ Unknown

*If positive, list anatomic site(s): _____

Culture of Tissue/Other Body Fluids: ◯ Positive* ◯ Negative ◯ Not Done ◯ Unknown

*If positive, list anatomic site(s): _____

Inmate's anticipated release date and address: ***A Discharge/Release summary and medication administration records must be sent to the TB Control Section in Tallahassee within one (1) business day of release or transfer.***

Expected Release Date: _____ Release County: _____

Release Address: _____ Phone #: _____

Emergency Contact's Name: _____ Phone #: _____

Additional Notes:

_____

_____

_____

Client Name: _____ DOB: _____

INITIAL TREATMENT PLAN

Site of presumptive disease: ◯Pulmonary ◯Extrapulmonary ◯Both

◯ ***Low clinical suspicion*** **–** If TB is considered unlikely, keep the patient in isolation until 1) Another diagnosis is made that explains the clinical syndrome **or** 2) The patient has 3 negative acid-fast bacilli (AFB) smears. A final decision about the TB diagnosis should be made within 8-9 weeks from the time the patient was reported as a suspect. Send medical record documentation of this decision to the FDOH TBCS within 3 days of the decision.

◯ ***High clinical suspicion OR No other diagnosis to explain the clinical syndrome –*** If TB is considered likely, start the patient on a 4-drug TB treatment regimen in accordance with CDC guidelines and keep the patient in isolation until the patient meets **all** of the following 3 criteria:
1. 3 negative AFB sputum smears
2. The patient has been on four (4) anti-tuberculosis medications for at least 2 weeks
3. The patient is clinically improving on treatment

Please ensure one of the four (4) available weight-based regimens have been prescribed in accordance with CDC/ATS guidelines and indicate the regimen number below. CDC guidelines available at: http://www.cdc.gov/mmwr/PDF/rr/rr5211.pdf and http://www.cdc.gov/mmwr/PDF/wk/mm5351.pdf (errata).

Treating clinician: _____ **Contact Phone Number:** _____

☐ ***Sputum Collection –*** **Please send all specimens to the State Public Health Lab in Jacksonville, Florida. Attach copies of the requisitions, preliminary results, or culture results to this report; whichever is available at the time of reporting. Laboratory requisitions and special shipping containers can be obtained by calling the lab: (904) 791-1630**

Collect 3 sputum specimens for NAA (1st specimen only), AFB smear and culture for all TB suspects and cases, regardless of the site of disease. Specimens should be collected at least 8 hours apart, and at least one should be an early morning specimen.

Requested frequency for patients on anti-TB treatment:
1. Weekly until 3 consecutively negative AFB smear results are reported; then
2. Every two weeks until 2-3 negative cultures are reported; then
3. Monthly there after (minimum requirement)

☐ ***Chest Radiography:***

If there are concerns regarding responsiveness to treatment, or in the event that a patient is culture negative but TB is still suspected, and the initial chest radiograph is abnormal, repeat the radiographic examination for comparison in 8 weeks.

Medications **- Please attach a copy of the initial medication orders & Medication Administration Record (MARs) & send completed MARs to the TBCS on a monthly basis as follow-up.**

Date first dose was given: _____ Patient's weight at start of treatment: _____ lbs. /_____ kg

Current regimen: **Frequency (Daily, 2 x weekly, 3 x weekly)**

☐ Isoniazid _____mg**
☐ Rifampin _____mg**
☐ Pyrazinamide _____mg**
☐ Ethambutol _____mg**
☐ Streptomycin _____mg**
☐ Other, please specify name

Fax to: Florida Department of Health,
TB Control Section Attn:
Corrections Liaison
Office: 941-748-0747 Ext. 1476
Fax: 850-921-9906

*Indicate CDC/ATS Regimen # prescribed for this client: _____
***Directly Observed Therapy (DOT) Required*

Additional Notes: