Last Name	First Name	MI
Patient Number		
Date of Birth	Month / Day / Year	
Race		

Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐Unknown

Primary language: ☐ English ☐ Other ____________________

English proficiency: ☐ Understands ☐ Speaks ☐ Reads

Can patient read in primary language? ☐ Yes ☐ No

Gender: ☐ Female ☐ Male

Allergies:

N.C. Department of Health and Human Services
Division of Public Health
Epidemiology Section • TB Control

Tuberculosis Epidemiological Record

Occupation(s): ____

County of Residence: ____

Address: ____

Phone: ____

Primary care MD (PMD): ____

If no PMD, was a referral made to get patient into care? ☐ Yes ☐ No

Was an interpreter necessary for this interview? ☐ Yes ☐ No

Country of birth of guardians if < 15 years old:

____

Contact to case? ☐ Yes ☐ No Year of contact: ________________

Source case name: ____

Reason for presenting to TB clinic:

☐ Job/administrative screening ☐ Contact investigation ☐ Refugee/Class B ☐ Medical risk for TB ☐ Outreach screening
☐ Confirmed active TB ☐ Population risk for TB ☐ Medical risk for TB ☐ Suspected active TB ☐ Confirmed active TB
☐ Other ____ Patient referred by a health care provider: ☐ Yes ☐ No

Medications:

(circle) **TST / TSPOT / QFT:** Testing site ___________ Date placed_________ Date read _________ Result _________mm / other

(circle) **TST / TSPOT / QFT:** Testing site ___________ Date placed_________ Date read _________ Result _________mm / other

Prior treatment for LTBI: ☐ No ☐ Yes (dates)____________ Prior treatment for active TB: ☐ No ☐ Yes (dates)________________

If previously treated were there any complications during treatment:____

HIV status: ☐ POS ☐ NEG ☐ Refused ☐ Not Offered ☐ Unknown If positive: CD4 count:________________

On ART? ☐ Yes ☐ No If no, was referral made? ☐ Yes ☐ No HIV Meds:

Y	N	TB SYMPTOMS
☐	☐	Severe Cough lasting at least 3 weeks
☐	☐	Hemoptysis
☐	☐	Persistent fever not explained by another condition
☐	☐	Night sweats
☐	☐	Chest pain not explained by another condition
☐	☐	Shortness of breath
☐	☐	Poor appetite
☐	☐	Unintentional Weight loss (amount ________________)
☐	☐	Swollen glands in neck
☐	☐	Cervical lymphadenopathy on nurse exam

Symptom onset date:____________ Weight:____________

Height:____________ BMI:____________

Resident of a long-term care facility. (If yes select one)

☐ Nursing home
☐ Hospital based facility
☐ Residential Assisted living
☐ Mental health residential facility
☐ Alcohol or drug treatment facility (> 30 days)
☐ Other type of residential facility (> 30 days)

Nurse:____

Signature:____

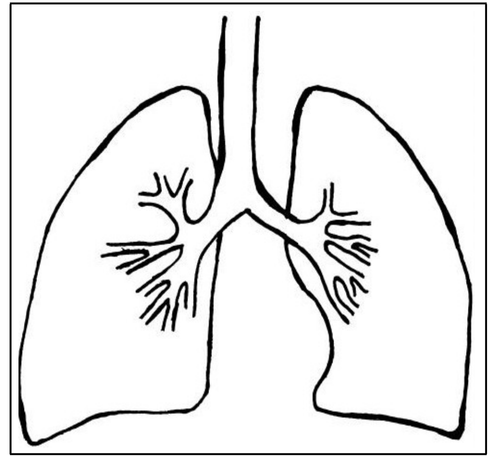
Date:________________________________

Y	N	MEDICAL HISTORY AND RISK FACTORS
☐	☐	Solid organ transplant recipient
☐	☐	Patient is Immunosuppressed/ immunocompromised due to either a medical condition (e.g., leukemia, Hodgkin's lymphoma, carcinoma of the head or neck), or immunosuppressive therapy, such as prolonged use of high-doses (> 15 mg/day) of corticosteroid)
☐	☐	Immigrant from high-incidence country. If yes: Country of birth________________ Date Immigrated: _________
☐	☐	Non prescribed non-injecting drugs in the past 12 months
☐	☐	Diabetes mellitus If yes, FBS:__________ HgA1C :__________ Diabetes complications:________________________
☐	☐	Underweight
☐	☐	End-stage renal disease (on dialysis)
☐	☐	Gastrectomy / jejunal bypass
☐	☐	Jail/prison history________________________
☐	☐	Homeless in the last 12 months / Ever Homeless ☐ Yes ☐ No
☐	☐	Ever a Healthcare worker
☐	☐	Ever a migrant/seasonal worker / Silicosis ☐ Yes ☐ No
☐	☐	Ever a correctional facility employee
☐	☐	Pregnant LMP_____/_____/_______
☐	☐	Using birth control (type)________________________
☐	☐	Currently breastfeeding
☐	☐	Lung disease (name)________________________
☐	☐	Hepatitis B or C (chronic or acute)
☐	☐	Other liver disease (name)________________________
☐	☐	Resided or traveled outside the USA for ≥ 2 months
☐	☐	Heavy alcohol use in the last 12 months (Heavy is defined as ≥ 5 drinks per day for men and 4 for women on ≥ 5 days/month. 1 drink = 12 oz beer = 4 oz wine = 1 shot liquor)

Smoking (select one) ☐Never ☐Former ☐Some days ☐Every day

Tobacco use? (select one) ☐Never ☐Former ☐Current

Film #____________________Location where taken:________________________



CHEST RADIOGRAPH Date: ____/____/______ ☐ Check if end of treatment

CXR Result:

☐ Normal ☐ Cavity ☐ Mediastinal lymphadenopathy
☐ Abnormal ☐ Infiltrate ☐ Pleural thickening
☐ Pleural effusion ☐ Granuloma ☐ Scarring
☐ Atelectasis ☐ Nodules

Comments on CXR:

Physician notes and examination

Prior Chest radiograph date: ____/____/______

Comparison:

☐ Improved ☐ No change ☐ Worse

CURRENT STATUS:

☐ No further TB f/u needed ☐ Evaluation in progress ☐ Latent TB ☐ Suspected active TB ☐ Confirmed active TB

ORDERS:

ALL PATIENTS ARE TO BE MONITORED PER NC STATE AND COUNTY TB POLICIES.

☐ Sputum x 3 for AFB, then x 2 q 2 weeks ☐ Draw hepatic function panel monthly ☐ Other ________________________________

☐ Respiratory isolation ☐ Close to TB follow up ☐ May use Video Directly Observed Therapy (DOT)

☐ **Treat for latent TB infection:**

- ☐ Rifampin ______mg po x 4 months daily
  - ☐ Self-administered
  - ☐ Directly observed
- ☐ Isoniazid ______mg + Rifapentine ______mg po once-weekly x 12 weeks ☐ directly observed ☐ self-administered
- ☐ Isoniazid ______mg po x ______months
  - ☐ Daily, self-administered
  - ☐ Twice-weekly, directly observed
  - ☐ Isoniazid _______________mg + Rifampin ______mg po daily x 12 weeks ☐ directly observed ☐ self-administered

☐ **Treat for active TB using DOT**

- ☐ Isoniazid ______ mg po daily for 8 weeks
- ☐ Rifampin ______ mg po daily for 8 weeks
- ☐ Pyrazinamide ______ mg po daily for 8 weeks
- ☐ Ethambutol ______ mg po daily for 8 weeks
- ☐ _________ ______ mg po daily for 8 weeks
- ☐ B6 ______ mg po daily for 8 weeks

Followed by:

- ☐ Isoniazid ______ mg po ☐ daily ☐ thrice weekly for ______ weeks
- ☐ Rifampin ______ mg po ☐ daily ☐ thrice weekly for ______ weeks
- ☐ _________ ______ mg po ________ for ______ weeks
- ☐ _________ ______ mg po ________ for ______ weeks
- ☐ B6 ______ mg po ☐ daily ☐ thrice weekly for ______weeks

Physician's signature:____ **Date**:______________________