

**OFFICIAL REPORT OF ADULT* TUBERCULOSIS CASE/SUSPECT/LTBI**PHILADELPHIA DEPARTMENT OF HEALTH
TUBERCULOSIS CONTROL PROGRAM500 S. Broad Street, 2nd Floor

Philadelphia, PA 19146

Tel: 215-685-6873, Fax: 215-685-6477

*Adult ≥ 18 years old

PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, MIDDLE)		SOCIAL SECURITY NUMBER		DATE REPORTED ____/____/____	WEIGHT ____ lbs / kg
D.O.B ____/____/____	SEX <input type="checkbox"/> F <input type="checkbox"/> M	RACE <input type="checkbox"/> African-Amer <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native Amer <input type="checkbox"/> Other _____		HISPANIC <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	COUNTRY OF ORIGIN _____
STREET ADDRESS			CITY	ZIP CODE	
TELEPHONE # Home	Work or Mobile	OCCUPATION	EMPLOYER/SCHOOL <input type="checkbox"/> Daycare <input type="checkbox"/> School <input type="checkbox"/> Employer		
EMPLOYER/SCHOOL LOCATION		EMPLOYER/SCHOOL PHONE#		IF STUDENT or in CHILDCARE GRADE/ROOM _____	
EMERGENCY CONTACT NAME	EMERGENCY CONTACT ADDRESS		EMERGENCY CONTACT TELEPHONE#		

TB INFORMATION

SITE OF TB DISEASE <input type="checkbox"/> Pulmonary <input type="checkbox"/> Lymphatic: Cervical <input type="checkbox"/> Lymphatic: Intrathoracic <input type="checkbox"/> Lymphatic: Axillary <input type="checkbox"/> Lymphatic: Other _____ <input type="checkbox"/> Lymphatic: Unknown <input type="checkbox"/> Laryngeal <input type="checkbox"/> Bone and/or Joint <input type="checkbox"/> Genitourinary <input type="checkbox"/> Meningeal <input type="checkbox"/> Peritoneal <input type="checkbox"/> Pleural <input type="checkbox"/> Other _____	SPUTUM SMEAR Date Collected ____/____/____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown SPUTUM CULTURE Date Collected ____/____/____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown Laboratory _____	SMEAR/PATHOLOGY/CYTOLOGY OF TISSUES & OTHER BODILY FLUIDS Date Collected ____/____/____ Anatomic site _____ Type of Exam <input type="checkbox"/> Smear <input type="checkbox"/> Cytology/Pathology Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown CULTURE OF TISSUES & OTHER BODILY FLUIDS Date Collected ____/____/____ Anatomic site _____ Laboratory _____ Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
STATUS AT TIME OF DIAGNOSIS <input type="checkbox"/> Alive <input type="checkbox"/> Dead If yes, date of death ____/____/____	PREVIOUS DIAGNOSIS OF TB (NOT LTBI) Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, year of diagnosis _____	

INITIAL CHEST RADIOGRAPH (XRAY) Date ____/____/____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown If abnormal, reason: <input type="checkbox"/> Evidence of a cavity <input type="checkbox"/> Evidence of miliary TB <input type="checkbox"/> Other _____	INITIAL CHEST CT SCAN OR OTHER IMAGING STUDIES Date ____/____/____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown If abnormal, reason: <input type="checkbox"/> Evidence of a cavity <input type="checkbox"/> Evidence of miliary TB <input type="checkbox"/> Other _____
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LABORATORY VALUES

Liver Function Tests

Date ___/___/___

ALT ___ AST ___ TBili ___ Creat ___ Alk Phos ___

Other _____

CBC

Date ___/___/___

WBC ___ Hgb ___ Hct ___ Platelets ___

Other _____

Nucleic Acid Amplification Test

Date ___/___/___

Anatomic Site _____

Result

Positive Negative Indeterminate Unknown

Laboratory _____

Interferon Gamma Release Assay for MTB

Date ___/___/___

Test Type (Specify) _____

Result

Positive Negative Indeterminate Unknown

Laboratory _____

HIV Status

Date tested ___/___/___

Result:

Positive Negative Indeterminate Unknown

Tuberculin (Mantoux) Skin Test

Date tested ___/___/___

Result, _____ mm

Positive Negative Indeterminate Unknown

Primary Reason for Evaluation

- Abnormal CXR (consistent with TB)
- Contact Investigation
- Healthcare Worker
- Incidental Lab Result

TB Symptoms

- Cough
- Hemoptysis
- Weight Loss _____ lbs / kg
- Night Sweats

Reason for Referral to TB Control (Please provide a brief Clinical Summary) -

DRUG REGIMEN

Drug	Dose	Date Started	Date Stopped
Isoniazid	_____ mg	___/___/___	___/___/___
Rifampin	_____ mg	___/___/___	___/___/___
Pyrazinamide	_____ mg	___/___/___	___/___/___
Ethambutol	_____ mg	___/___/___	___/___/___
Pyridoxine (Vitamin B6)	_____ mg	___/___/___	___/___/___
Other _____	_____ mg	___/___/___	___/___/___
Other _____	_____ mg	___/___/___	___/___/___
Other _____	_____ mg	___/___/___	___/___/___

Frequency

Daily 2x a week 3x a week 5x a week Other _____ Allergies _____

HOSPITALIZATION

HOSPITAL	ADMISSION DATE ___/___/___	DISCHARGE DATE ___/___/___
ATTENDING PHYSICIAN	ADDRESS	TELEPHONE #
CELL #	FAX#	ADMITTING DIAGNOSIS

PRIMARY CARE PROVIDER

PRIMARY CARE PROVIDER	ADDRESS	TELEPHONE #
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ADULT TB CASES OR SUSPECTS MUST BE REPORTED TO THE HEALTH DEPARTMENT USING THIS FORM WITHIN 24 HOURS

FAX COMPLETED FORM TO 215-685-6477