

TUBERCULOSIS SURVEILLANCE AND CASE MANAGEMENT REPORT



Colorado Department of Public Health and Environment
Tuberculosis Program
4300 Cherry Creek Drive South
DCEED-TB-A3
Denver, Colorado 80246-1530
(303) 692-2638 phone (303) 759-5538 Fax

DEMOGRAPHICS			LOCATING INFORMATION		
Last Name _____ Date of Birth _____ / _____ / _____ Race: <input type="checkbox"/> American <input type="checkbox"/> Indian/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Is. <input type="checkbox"/> White <input type="checkbox"/> Unknown Occupation: <input type="checkbox"/> New health care worker <input type="checkbox"/> Current health care worker (HAS patient contact) <input type="checkbox"/> Current health care worker (NO patient contact) <input type="checkbox"/> Corrections employee <input type="checkbox"/> Migrant farm worker <input type="checkbox"/> Unemployed past 24 months Employer _____	First Name _____ MI _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Ethnicity: <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino Country of Birth: <input type="checkbox"/> United States <input type="checkbox"/> Mexico _____ Specify other Date Arrived in US: _____ / _____ / _____ _____ Month/Year _____ Specify other	Current Home Address (Number & Street Name) _____ Apt # _____ City _____ State _____ Zip Code _____ County _____ Other Address (Number & Street Name) _____ Specify Type _____ City _____ State _____ Zip Code _____ County _____ () () Home Phone Number _____ Other Phone Number _____ Specify Type _____ () Work Phone Number _____			
TUBERCULIN SKIN TEST (TST)					
Current TST Type: <input type="checkbox"/> Mantoux- Tubersol <input type="checkbox"/> Mantoux- Aplisol <input type="checkbox"/> Mantoux- Unspecified <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	Reason For Test: <input type="checkbox"/> Administrative <input type="checkbox"/> Class B TB Notification <input type="checkbox"/> Contact investigation <input type="checkbox"/> Employment <input type="checkbox"/> Immigration status change <input type="checkbox"/> Known active <input type="checkbox"/> Source case investigation	<input type="checkbox"/> Suspect case <input type="checkbox"/> Symptomatic <input type="checkbox"/> Targeted testing- individual <input type="checkbox"/> Targeted testing- pregnancy <input type="checkbox"/> Targeted testing- specific project <input type="checkbox"/> Transfer case/suspect <input type="checkbox"/> Unknown	Name of Clinic/Local Health Agency Placing TST _____		
Current TST _____ / _____ / _____ mm Date Given _____ / _____ / _____ Date Read _____ / _____ / _____ Reading _____	Previous TST _____ / _____ / _____ mm Date _____ / _____ / _____ Reading _____	Current TST Result <input type="checkbox"/> Negative <input type="checkbox"/> Positive (please select criteria below) <input type="checkbox"/> Not read			
TST positive at 5 mm or greater <input type="checkbox"/> HIV positive person <input type="checkbox"/> Recent, close contact to active TB <input type="checkbox"/> Has fibrotic lesions on CXR consistent with previous TB disease <input type="checkbox"/> Patients with organ transplants or other immunosuppressed patients <input type="checkbox"/> TB suspects	TST positive at 10 mm or greater <input type="checkbox"/> Recent arrival from a country with a high prevalence of TB <input type="checkbox"/> Injection drug user <input type="checkbox"/> Resident of high risk congregate setting <input type="checkbox"/> Employee of high risk congregate setting <input type="checkbox"/> Mycobacteriology laboratory personnel <input type="checkbox"/> High risk clinical conditions <input type="checkbox"/> Child < 4 years old, or child or adolescent exposed to adult in high risk category	TST positive at 15 mm or greater <input type="checkbox"/> No known risk factors for TB			
QuantiferON (QFT)			X-RAY FINDINGS		
Collection Date _____ / _____ / _____ Testing Laboratory _____ QFT Results <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	Current CXR Results: _____ / _____ / _____ Date Taken _____ Previous CXR Results: _____ / _____ / _____ Date Taken _____	<input type="checkbox"/> Cavitation <input type="checkbox"/> Infiltrates <input type="checkbox"/> Pleural disease	<input type="checkbox"/> Non-TB abnormality <input type="checkbox"/> Normal <input type="checkbox"/> Other _____		
		<input type="checkbox"/> Cavitation <input type="checkbox"/> Infiltrates <input type="checkbox"/> Pleural disease	<input type="checkbox"/> Non-TB abnormality <input type="checkbox"/> Normal <input type="checkbox"/> Other _____		

Patient Last Name _____ First Name _____ MI _____ Date of Birth _____ / _____ / _____

MEDICAL HISTORY

Symptoms:
 None
 Cough > 3 wks _____
 Productive cough _____
 Hemoptysis _____
 Chest pain _____
 Weight loss _____
 Night sweats _____
 Urinary _____
 Fever _____
 Other (specify) _____

Symptom Length: _____

Alcohol Abuse:
 Yes
 No
 Unknown

Drug Abuse:
 Injecting
 Noninjecting
 No
 Unknown

Previous TB Diagnosis:
 Yes
 No
 Unknown

HIV Test:
 Yes
 No
 Unknown

HIV Result:
 Positive
 Negative
 Not done
 Unknown

Allergies: _____

Medications: _____

Weight: _____

HIV Test Date: _____ / _____ / _____

RISKS AND SPECIAL CONDITIONS

Exposure Risks:
 None
 Homeless
 Resident of correctional facility (if Yes check one)
 Federal prison
 State prison
 Local jail
 Juvenile
 Other _____
 Unknown

Resident of long term care facility (if Yes check one)
 Nursing home
 Hospital
 Residential
 Mental health
 Alcohol/drug treatment
 Other _____
 Unknown

TST conversion in last 2 years

Medical Risks:
 None
 Heart disease
 Diabetes mellitus
 Weight loss > 10 lbs
 Gastrectomy
 Jejunioleal bypass

Silicosis
 Immunosuppressive therapy
 Cancer
 Hepatitis
 Renal failure

Special Conditions:
 Pregnant EDC _____ / _____ / _____
 Postpartum breast feeding
 Other special conditions _____

TREATMENT

Current treatment
 Past treatment

Therapy Start Date: _____ / _____ / _____
 Therapy End Date: _____ / _____ / _____

Isoniazid _____ mg
 Rifampin _____ mg
 Pyrazinamide _____ mg
 Ethambutol _____ mg

Other _____ mg
 Other _____ mg
 Other _____ mg

Reason Stopped:
 Died
 Lost to follow-up
 Moved
 Adverse reaction

Course completed
 Uncooperative/refused
 Unknown
 Other _____

CASE COMPLETION

Final Case Status:
 Closed
 Moved away
 Lost contact
 Died
 Not determined

If Moved New Address (Number & Street Name) _____

City _____ State _____ Zip Code _____

SOURCE INFORMATION

If the person is a contact to an active case complete information on the source case

Last Name _____ First Name _____

Relation to Source _____ Exposure Dates _____ / _____ / _____ to _____ / _____ / _____

PROVIDER INFORMATION

Local Health Agency (LHA) _____ PCP/Clinic Name _____ PCP Phone Number _____ () _____

LHA Phone Number _____ LHA Fax Number _____ PCP/Clinic Address _____ PCP Fax Number _____ () _____

Nurse _____ PCP City _____ PCP State _____ PCP Zip Code _____

COMMENTS

Person completing form _____ Date _____ / _____ / _____