

TB COHORT PRESENTATION FORM

Date of cohort review:

Case Manager/Presenter:

Initials: _____

Patient Information		Status (Check One)		Risk Factors		
DOB (mm/dd/year)		Refugee	<input type="checkbox"/> YES <input type="checkbox"/> NO	Homeless	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Age		Immigrant	<input type="checkbox"/> YES <input type="checkbox"/> NO	Resident Correctional Facility	<input type="checkbox"/> YES <input type="checkbox"/> NO	
County		B1	<input type="checkbox"/> YES <input type="checkbox"/> NO	Resident Long Term Care Facility	<input type="checkbox"/> YES <input type="checkbox"/> NO	
ID number		B2	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other: Identify below	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Race		Non-documented Immigrant	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	Does not Apply – U. S. Born	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Country of birth						
Arrival Date		and or travel history:				
HEALTH HISTORY		SOCIAL HISTORY		MEDICAL HISTORY		
Alcohol Abuse	<input type="checkbox"/> YES <input type="checkbox"/> NO	Employment History:		Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	
IV Drug Use	<input type="checkbox"/> YES <input type="checkbox"/> NO			Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Non IV Drug Use	<input type="checkbox"/> YES <input type="checkbox"/> NO			Heart Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Cigarettes	<input type="checkbox"/> YES <input type="checkbox"/> NO			Lung Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	
List of MEDICATIONS (NOT TB):				Hepatitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	
		Family and Social Factors (language barriers, support system, etc.):		Arthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO	
				GI Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	
		If Ped Pt give parents' place of birth:		HIV	<input type="checkbox"/> YES <input type="checkbox"/> NO	
				Mental	<input type="checkbox"/> YES <input type="checkbox"/> NO	
				Other: Explain	<input type="checkbox"/> YES <input type="checkbox"/> NO	
				Symptoms	Date	Notes
<input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra Pulmonary	Type:	Case Classification:		Cough		
<input type="checkbox"/> Culture Confirmed Case <input type="checkbox"/> Clinical Case				Weight Loss		# over time:
Reason for Evaluation				Night Sweats		
Evaluation done by:				Chest Pain		
TST/IGRA Date				Lymphadenopathy		Location:
IGRA Result:		Or mm measurement:		Fever		
Facility that provided test		Name:		Fatigue		
Chest X-Ray <input type="checkbox"/> YES <input type="checkbox"/> NO				Hematuria		
CT Scan <input type="checkbox"/> YES <input type="checkbox"/> NO				SOB		
<input type="checkbox"/> Cavitory <input type="checkbox"/> Noncavitory				Hemoptysis		
Sample sent to		Lab Name:		Other		Explain:
Initial Smear Results		<input type="checkbox"/> Positive <input type="checkbox"/> Negative		Date Initial Sputum collected		Collected by whom?
Date County notified of probe results:		Numerical Value:		Lab received on		
Smear conversion date:		Culture Confirmed <input type="checkbox"/> YES <input type="checkbox"/> NO		MTB Probe Done? <input type="checkbox"/> YES <input type="checkbox"/> NO		MTB Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Other anatomical specimens?		Culture conversion date:		Date Notified of Sensitivity Results:		Pan Sensitive <input type="checkbox"/> YES <input type="checkbox"/> NO
Baseline Lab (CBC, liver panel, blood sugar, uric acid)		Date:		What are resistant drugs if applicable		
		Source		Smear/Culture results:		
				HIV Test	Date:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative

TB Treatment							
Initiation Phase Started	Date:			Continuation Phase Started	Date:		
Treating Physician's Name				# of months (4/7)			
Patient's Weight in Kilos							
Drug	Dosage	Date or estimate date of completion	# of doses	Drug	Dosage	Date or estimate date of completion	# of doses
DOT <input type="checkbox"/> daily except weekends <input type="checkbox"/> No, why?							
Breaks in DOT? <input type="checkbox"/> No <input type="checkbox"/> Yes, why?							
End of Treatment Date		Check One: <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> No Change <input type="checkbox"/> Not Done		Date	Weight (Kilos)	Height (cm)	BMI
Date Most Current Chest X-Ray				Beginning:			
Did you do a contact investigation? <input type="checkbox"/> YES <input type="checkbox"/> NO, why?				Approximately 2 Months:			
Date contact investigation initiated (interview):				End of Treatment:			
PLEASE FILL IN THE BLANKS with the Number of...				PLEASE FILL IN THE BLANKS with the Number of...			
High risk contacts identified				Rescreened positive tests			
Previous positive contacts				Rescreened negative tests:			
High risk contacts tested initially/evaluated, including CXR when indicated				Contacts started on LTBI treatment:			
Date First Screening Done:				Clients currently on treatment:			
Initial positive tests				Clients who refused treatment			
Negative tests				Clients who discontinued treatment			
Active cases identified due to screening				Reason treatment was discontinued: <input type="checkbox"/> Due to adverse reaction <input type="checkbox"/> Moved <input type="checkbox"/> Lost to follow up <input type="checkbox"/> Provider decision			
Active cases identified due to screening							
Contacts screened 2nd time (8-10 wks after exposure):							

Fax Form to: (402) 471-1377

Be sure and initial the form at the top before you send it!