COHORT PRESENTATION FORM -2015

Date of cohort review_____

Case Manager/presenter_____

Initials/BD_____County_____

Age/Race/Sex_____Country of Birth_____

Arrival Date and/or travel Hx-_____

Refugee / Immigrant / B1 / B2 / non-documented immigrant / does not apply - US born

Risk Factors: Homelessness/ Correctional Facility Resident/ Long Term Facility Resident/ other:

_____

Hx of Alcohol abuse / Drug use- IV or Non IV / Cigarettes (circle all that apply)

Employment Hx: _____

Family and Social Factors (language barriers, support system, etc.):_____
(If Ped pt give parents place of birth)

_____

Medical Hx: Diabetes/Cancer/ Ht disease/Lung disease/Hepatitis/Arthritis/ GI disease/HIV /Mental
(circle all that apply)

_____

Medications (not TB):_____

Pulmonary / Extra pulmonary (type) _____

Culture Confirmed case/ clinical case (circle case classification)

Reason for Evaluation and by who: _____

_____

Symptoms/date of start Cough_____
Wt Loss, # over time_____ Fever_____
Night Sweats _____ Fatigue_____
Chest Pain_____ SOB_____
Lymphadenopathy (location) _____ Hemoptysis_____
Hematuria_____Other_____

TST/IGRA-date _____ IGRA result or mm measurement _____

Facility that provided test_____

Chest X-ray /CT scan (please attach copy of report): date_____

Cavitary or Noncavitary (circle one).

PULMONARY TB DISEASE

Initial Sputum collection date _____ _____Collected by whom_____

Date Lab received _____Lab name_____

Initial Smear results- Pos_____ (indicate numerical value)/ Neg

NAAT date if done_____ Result of NAAT _ Pos / Neg Date Notified_____

Date culture confirmed _____

Date notified and results of sensitivity testing_____

Smear conversion date _____Culture conversion date _____

Baseline (CBC, liver panel, blood sugar, uric acid) lab normal / abnormal _____

HIV date _____Status_____

TB Treatment: Initiation Phase: Date started_____
Treating Dr. _____ Pt WT- Kilos _____

Drug	Dosage	Date D/C	# of doses

Continuation Phase: - Date started # of _____months (4/7)

Drug	Dosage	Date or Estimate of date of completion	# of doses

DOT: daily except weekends, why if not _____
Breaks in Dot? Yes/ No, Due to ?_____

Treatment interruptions? Yes/ NO – Explain_____

End of Treatment or most current Chest X-ray _____

Improved/ worsened/no change/not done. (circle appropriate description)

Beginning - date/ WT(Kilos) _____ HT (cm)_____ BMI_____

Approx 2months date/wt: _____ End of tx date/wt: _____

Contact Investigation Worksheet - 2015

Did you do a contact investigation? Yes/ No If not why not?_____ _____

Contact investigation: Estimated date when patient became infectious: _____

Date contact investigation initiated (interview)_____

# of high risk contacts identified_____ # of previous pos contacts _____

# of high risk contacts tested initially/evaluated, including cxr when indicated _____

Date 1st screening test done _____

#of Initial pos tests _____# of Neg tests_____

Active cases identified due to screening _____

# of contacts put on window treatment _____

# of contacts screened 2nd time(8-10 wks after exposure) _____

# of rescreened pos tests_____# neg tests _____

# of contacts started on LTBI tx _____

 # currently on tx _____# refused _____

 # discontinued tx_____

Due to adverse reaction_____moved_____

Lost to follow up_____Provider decision_____

Contact Summary:

High risk contacts # completed eval._____Outcomes_# Neg_____#LTBI_____

Medium risk contacts # completed eval._____Outcomes_# Neg_____#LTBI_____

Low risk contacts # completed eval._____Outcomes_# Neg_____#LTBI_____

Total: # completed eval._____Outcomes_# Neg_____#LTBI_____

EXTRA-PULMONARY TB DISEASE -2015

Specimen Type _____

Date of Collection_____

Lab that Processed Specimen _____

Smear results_____

Culture results _____

Pan Sensitive/ resistant drugs_____

Pathology Reports _____

Sputum collected Yes/ No **Date of collection** _____

Date and result of Sputum smear and culture _____

Baseline (CBC, liver panel, blood sugar, uric acid) lab normal / abnormal _____

HIV date _____**Status**_____

TB Treatment: Initiation Phase: Date started_____

Treating Dr. _____ **Pt WT- Kilos** _____

Drug	Dosage	Date D/C	# of doses

Continuation Phase: - Date started **# of** _____**months (4/7)**

Drug	Dosage	Date or Estimate of date of completion	# of doses

DOT: daily except weekends, why if not _____
Breaks in Dot? Yes/ No, Due to ?_____

Treatment interruptions? Yes/ NO – Explain_____

Beginning - date/ WT(Kilos) _____ **HT (cm)**_____ **BMI**_____

Approx 2months date/wt: _____ **End of tx date/wt:** _____