Print Form

State of CT Department of Public Health
Tuberculosis Control Program
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TUBERCULOSIS THERAPY AND FOLLOW-UP CARE REPORT FORM (TB-32)

Voice: (860) 509-7722 **Fax: (860) 509-7743**

CASE NUMBER: *(For Office Use Only)*

PATIENT'S NAME: (LAST, FIRST, MIDDLE)

DATE OF BIRTH: MM DD YYYY

DATE OF THIS EVALUATION: MM DD YYYY

ADDRESS: (STREET, CITY, STATE, ZIP)

HOME TELEPHONE: ( )

DATE OF NEXT EVALUATION: MM DD YYYY

THIS PATIENT IS BEING TREATED FOR: (CHECK ONE) ☐ ACTIVE TB DISEASE ☐ LATENT TB INFECTION

START DATE: MM DD YYYY

MONTHS OF TREATMENT TO DATE

THERAPY STATUS:

☐ CONTINUING

☐ RESTARTED (COMPLETE RESTART DATE AT RIGHT AND REASON/DATE RX HAD STOPPED BELOW)

IF RESTARTED, DATE : MM DD YYYY

☐ THERAPY STOPPED (COMPLETE REASON/DATE STOPPED AT RIGHT)

DATE THERAPY STOPPED: MM DD YYYY

TOTAL MONTHS OF TREATMENT:

CHECK DRUGS(S) / COMPLETE DOSAGES FOR CURRENT TREATMENT

☐ ISONIAZID _____ MG ☐ OTHER _____ MG (SPECIFY)

☐ RIFAMPIN _____ MG ☐ OTHER _____ MG (SPECIFY)

☐ PYRAZINAMIDE _____ MG ☐ OTHER _____ MG (SPECIFY)

☐ ETHAMBUTOL _____ MG ☐ OTHER _____ MG (SPECIFY)

IF ONE OR MORE DRUGS WERE STOPPED, PLEASE INDICATE WHICH DRUG (S) AND DATE:

PROVIDE REASON THERAPY STOPPED FOR PATIENTS STOPPING TREATMENT. IF PATIENT IS RESTARTING, PROVIDE REASON/DATE RX HAD STOPPED:

☐ COMPLETED THERAPY ☐ OTHER _____ (SPECIFY)

☐ LOST ☐ DIED

DATE OF DEATH: MM DD YYYY

☐ REFUSED

☐ ADVERSE TREATMENT EVENT ☐ DEATH RELATED TO TB DISEASE

☐ NOT TB ☐ DEATH NOT RELATED TO TB DISEASE

☐ MOVED (ENTER NEW ADDRESS BELOW): ☐ DEATH RELATED TO TB THERAPY

_____ (NEW ADDRESS)

IF MOVED, RECORDS SENT TO NEW PROVIDER/HEALTH DEPARTMENT? ☐ YES ☐ NO

DIRECTLY OBSERVED THERAPY (DOT) (COMPLETE FOR THOSE CONTINUING OR STOPPING TREATMENT):

IS/WAS CLIENT ON DOT ☐ YES, BOTH DOT AND SELF-ADMINISTERED

☐ YES, TOTALLY DOT ☐ NO, TOTALLY SELF ADMINISTERED

IF YES, TO DATE NUMBER OF DOSES _____ NUMBER OF WEEKS _____

REASON THERAPY EXTENDED >12 MONTHS (SELECT ALL THAT APPLY):

☐ RIFAMPIN RESISTANCE ☐ TREATMENT FAILURE

☐ ADVERSE DRUG REACTION ☐ CLINICALLY INDICATED (PLEASE SPECIFY)

☐ NON-ADHERENCE _____ (SPECIFY)

HIV

ALL TB PATIENTS SHOULD HAVE HIV COUNSELING AND TESTING OFFERED. IF HIV C/T WAS PENDING OR NOT INITIALLY OFFERED, WHAT ARE THE RESULTS NOW ?

☐ POS (+) ☐ STILL PENDING

☐ NEG (-) ☐ REFUSED

DATE OF TEST: MM DD YYYY

ADDITIONAL TESTING

DATE TESTED: MM DD YYYY

☐ TUBERCULIN SKIN TEST

☐ INTERFERON RELEASE GAMMA ASSAY

☐ POSITIVE ☐ INDETERMINATE

☐ NEGATIVE ☐ PENDING

INDURATION SIZE: (IF 0 ENTER 0) MM

COMPARATIVE CXR/CT SCAN

DATE OF XRAY/OTHER: MM DD YYYY

☐ CHEST XRAY ☐ CT SCAN

☐ OTHER _____

RESULTS: ☐ IMPROVING ☐ STABLE ☐ WORSENING

FOLLOW UP LAB

SPUTUM CULTURE CONVERSION DOCUMENTED?

IF YES, ENTER DATE SPECIMEN COLLECTED FOR FIRST CONSISTENTLY NEGATIVE SPUTUM CULTURE: MM DD YYYY

☐ YES

☐ NO

IF NO, ENTER REASON FOR NOT DOCUMENTING SPUTUM CULTURE CONVERSION (SELECT ONE)

☐ NO FOLLOW-UP SPUTUM DESPITE INDUCTION ☐ PATIENT LOST ☐ DIED

☐ NO FOLLOW-UP SPUTUM AND NO INDUCTION ☐ PATIENT REFUSED ☐ OTHER (SPECIFY) _____

RISK FACTORS

AT TIME OF DIAGNOSIS WAS CLIENT KNOWN TO BE: (CHECK ALL THAT APPLY)

☐ USING INJECTION DRUGS ☐ USING NON-INJECTING DRUGS ☐ USING EXCESS ALCOHOL ☐ HOMELESS

MEDICAL PROBLEMS/ COMMENTS

DID CLIENT HAVE ADDITIONAL HOSPITALIZATIONS? ☐ YES ☐ NO

MEDICAL RECORD NUMBER: _____

REASON FOR HOSPITALIZATION/MEDICAL PROBLEMS/COMMENTS:

PROVIDER INFORMATION

CURRENT HEALTH CARE PROVIDER: (NAME, ADDRESS)

TELEPHONE: ( )

FAX: ( )

NAME OF PERSON COMPLETING THIS REPORT:

TELEPHONE: ( )

DATE OF THIS REPORT: MM DD YYYY