OFFICIAL REPORT OF ADULT* TUBERCULOSIS CASE/SUSPECT/LTBI

Philadelphia Department of Public Health
Disease Control

PHILADELPHIA DEPARTMENT OF HEALTH
TUBERCULOSIS CONTROL PROGRAM
1930 S. Broad Street, Unit #36
Philadelphia, PA 19145
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	RACE	HISPANIC	COUNTRY OF ORIGIN
___/____/___	☐F ☐M	☐African-Amer ☐White ☐Asian ☐Pacific Islander ☐Native Amer ☐Other _____	☐Y ☐N ☐U	_____

STREET ADDRESS	CITY	ZIP CODE

TELEPHONE # Home / Work or Mobile	OCCUPATION	EMPLOYER/SCHOOL ☐ Daycare ☐ School ☐ 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

☐ Pulmonary
☐ Lymphatic: Cervical
☐ Lymphatic: Intrathoracic
☐ Lymphatic: Axillary
☐ Lymphatic: Other _____
☐ Lymphatic: Unknown
☐ Laryngeal
☐ Bone and/or Joint
☐ Genitourinary
☐ Meningeal
☐ Peritoneal
☐ Pleural
☐ Other _____

STATUS AT TIME OF DIAGNOSIS

☐ Alive
☐ Dead If yes, date of death ___/___/___

SPUTUM SMEAR

Date Collected ____/____/__
☐ Positive
☐ Negative
☐ Not done
☐ Unknown

SPUTUM CULTURE

Date Collected ____/____/__
☐ Positive
☐ Negative
☐ Not done
☐ Unknown

Laboratory _____

PREVIOUS DIAGNOSIS OF TB (NOT LTBI)

Y N U
☐ ☐ ☐ If yes, year of diagnosis _____

SMEAR/PATHOLOGY/CYTOLOGY OF TISSUES & OTHER BODILY FLUIDS

Date Collected ____/____/__
Anatomic site _____
Type of Exam
☐ Smear
☐ Cytology/Pathology
Results
☐ Positive
☐ Negative
☐ Not done
☐ Unknown

CULTURE OF TISSUES & OTHER BODILY FLUIDS

Date Collected ____/____/__
Anatomic site _____
Laboratory _____
Results
☐ Positive
☐ Negative
☐ Not done
☐ Unknown

INITIAL CHEST RADIOGRAPH (XRAY)

Date ____/____/__
☐ Normal ☐ Abnormal ☐ Not Done ☐ Unknown
If abnormal, reason:
☐ Evidence of a cavity
☐ Evidence of miliary TB
☐ Other _____

INITIAL CHEST CT SCAN OR OTHER IMAGING STUDIES

Date ____/____/__
☐ Normal ☐ Abnormal ☐ Not Done ☐ Unknown
If abnormal, reason:
☐ Evidence of a cavity
☐ Evidence of miliary TB
☐ Other _____

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 #

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