



Connecticut Department of Public Health
 Tuberculosis Control Program
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Tuberculosis Treatment and Follow-up Care Report Form

Complete for ALL TB Disease and Latent TB Infection

PATIENT INFORMATION			
Patient Name – Last, First, Middle	Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (specify): _____	Date of Birth _____	Date of This Evaluation _____
Address – Street, City, State, Zip		Best Phone Number	Date of Next Evaluation _____
This patient is being treated for (please check one): <input type="checkbox"/> Active TB Disease <input type="checkbox"/> Latent TB Infection		Patient's insurance status (if changed/new): <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> TB Medicaid <input type="checkbox"/> Private <input type="checkbox"/> Other (specify): _____	

CURRENT TREATMENT													
<p>Start Date _____</p> <p>Please complete for all current medications, include dosage per mg.</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Isoniazid _____</td> <td><input type="checkbox"/> Pyridoxine (B6) _____</td> </tr> <tr> <td><input type="checkbox"/> Rifampin _____</td> <td><input type="checkbox"/> Rifapentine _____</td> </tr> <tr> <td><input type="checkbox"/> Ethambutol _____</td> <td><input type="checkbox"/> Rifabutin _____</td> </tr> <tr> <td>End Date: _____</td> <td><input type="checkbox"/> Other drug/dose _____</td> </tr> <tr> <td><input type="checkbox"/> Pyrazinamide _____</td> <td><input type="checkbox"/> Other drug/dose _____</td> </tr> <tr> <td>End Date: _____</td> <td><input type="checkbox"/> Other drug/dose _____</td> </tr> </table> <p>If one or more drugs were stopped, please indicate which drug(s) and date: _____</p> <p>Directly Observed Therapy (DOT)</p> <p>Is/Was Patient on DOT? <input type="checkbox"/> No, totally self-administered <input type="checkbox"/> Yes, totally DOT If Yes, was it: <input type="checkbox"/> In Person DOT <input type="checkbox"/> Electronic DOT <input type="checkbox"/> Yes, both DOT and self-administered</p> <p>If yes, number of doses to date: _____</p>	<input type="checkbox"/> Isoniazid _____	<input type="checkbox"/> Pyridoxine (B6) _____	<input type="checkbox"/> Rifampin _____	<input type="checkbox"/> Rifapentine _____	<input type="checkbox"/> Ethambutol _____	<input type="checkbox"/> Rifabutin _____	End Date: _____	<input type="checkbox"/> Other drug/dose _____	<input type="checkbox"/> Pyrazinamide _____	<input type="checkbox"/> Other drug/dose _____	End Date: _____	<input type="checkbox"/> Other drug/dose _____	<p>Treatment Status</p> <p><input type="checkbox"/> Continuing <input type="checkbox"/> Completed</p> <p>Total Months of Treatment: _____ Date completed: _____</p> <p><input type="checkbox"/> Treatment Stopped (Complete date stopped and check reason below)</p> <p>Date treatment stopped: _____ Provide reason treatment was stopped: <input type="checkbox"/> Refused <input type="checkbox"/> Not TB <input type="checkbox"/> Adverse Treatment Event <input type="checkbox"/> Lost <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Died Date died: _____</p> <p><input type="checkbox"/> Restarted Date restarted: _____ <input type="checkbox"/> Moved (enter new address below)</p> <p>New Address: _____</p> <p>Email address: _____</p> <p>If moved, were records sent to new provider/health department? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<input type="checkbox"/> Isoniazid _____	<input type="checkbox"/> Pyridoxine (B6) _____												
<input type="checkbox"/> Rifampin _____	<input type="checkbox"/> Rifapentine _____												
<input type="checkbox"/> Ethambutol _____	<input type="checkbox"/> Rifabutin _____												
End Date: _____	<input type="checkbox"/> Other drug/dose _____												
<input type="checkbox"/> Pyrazinamide _____	<input type="checkbox"/> Other drug/dose _____												
End Date: _____	<input type="checkbox"/> Other drug/dose _____												

NEW TESTING AND FOLLOW-UP INFORMATION. PLEASE ATTACH COPIES OF ALL NEW RESULTS

HIV	All TB patients should have testing. If HIV testing was pending, or not initially offered, what are the results now?	<input type="checkbox"/> Positive <input type="checkbox"/> Pending <input type="checkbox"/> Negative <input type="checkbox"/> Refused <input type="checkbox"/> Indeterminate	Date Tested _____
HEPATITIS	Was patient tested for hepatitis? <input type="checkbox"/> No <input type="checkbox"/> Yes Tests performed and results:	<input type="checkbox"/> HBV <input type="checkbox"/> Neg <input type="checkbox"/> Pos <input type="checkbox"/> HCV <input type="checkbox"/> Neg <input type="checkbox"/> Pos	Date Tested _____
COMPARATIVE IMAGING	Recommended TWO months after treatment started for TB disease. <input type="checkbox"/> CXR <input type="checkbox"/> CT Scan <input type="checkbox"/> Other: _____	Results: <input type="checkbox"/> Stable <input type="checkbox"/> Improving <input type="checkbox"/> Worsening	Date Tested _____
BACTERIOLOGY	Date of FIRST consistently negative sputum culture: _____	If no sputum culture conversion within 60 days (select one): <input type="checkbox"/> Still positive culture <input type="checkbox"/> Patient Lost <input type="checkbox"/> Died <input type="checkbox"/> NO follow-up sputum despite induction <input type="checkbox"/> Patient Refused <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> NO follow-up sputum and NO induction	
ADDITIONAL INFORMATION	Comments: _____		
PROVIDER INFORMATION	Current Provider Name, Facility Name and Address		Telephone: _____
			Fax: _____
	Name of Person Completing This Report	Telephone: _____	Date of This Report