Connecticut Department of Public Health
Tuberculosis Control Program
410 Capitol Avenue, MS #11TUB
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Tuberculosis Treatment and Follow-up Care Report Form

Complete for ALL TB Disease and Latent TB Infection

Rev. 1/1/2020

PATIENT INFORMATION

Patient Name – Last, First, Middle	Sex at Birth ☐ Male ☐ Female ☐ 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):

☐ Active TB Disease ☐ Latent TB Infection

Patient's insurance status (if changed/new):

☐ Uninsured ☐ Medicare ☐ Medicaid ☐ TB Medicaid ☐ Private ☐ Other (specify): _____

CURRENT TREATMENT

Start Date

_____

Please complete for all current medications, include dosage per mg.

☐ Isoniazid _____ ☐ Pyridoxine (B6) _____

☐ Rifampin _____ ☐ Rifapentine _____

☐ Ethambutol _____ ☐ Rifabutin _____

End Date: _____ ☐ Other drug/dose _____

☐ Pyrazinamide _____ ☐ Other drug/dose _____

End Date: _____ ☐ Other drug/dose _____

If one or more drugs were stopped, please indicate which drug(s) and date:

_____

Directly Observed Therapy (DOT)

Is/Was Patient on DOT?

☐ No, totally self-administered
☐ Yes, totally DOT If Yes, was it: ☐ In Person DOT ☐ Electronic DOT
☐ Yes, both DOT and self-administered

If yes, number of doses to date: _____

Treatment Status

☐ Continuing
☐ Completed

Total Months of Treatment: _____ Date completed: _____

☐ Treatment Stopped (Complete date stopped and check reason below)

Date treatment stopped: _____

Provide reason treatment was stopped:

☐ Refused
☐ Not TB
☐ Adverse Treatment Event
☐ Lost
☐ Other: _____

☐ Died Date died: _____

☐ Restarted Date restarted: _____
☐ Moved (enter new address below)

New Address:

Email address: _____

If moved, were records sent to new provider/health department? ☐ Yes ☐ No

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

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

Fax copy to the CT Department of Public Health Tuberculosis Program's confidential number, 860-509-7743; and to the Local Health Department.