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 ☐ 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	Date Tested ____
COMPARATIVE IMAGING	Recommended **TWO** months after treatment started for TB disease. ☐ CXR ☐ CT Scan ☐ Other: ____	Results: ☐ Stable ☐ Improving ☐ Worsening	Date Tested ____
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 Provider Name, Facility Name and Address		Telephone: Fax:
	Name of Person Completing This Report	Telephone:	Date of This Report ____