SAN BERNARDINO COUNTY

Public Health
Tuberculosis Control Program

Initial TB Case Report Form

Reporting of all patients with confirmed or suspect tuberculosis (TB) is mandated by the State of California Health and Safety Code. All TB cases and suspects must be reported within **one day of diagnosis**.

WHY DO YOU REPORT?

The health department performs many vital functions to ensure public health and safety, including case management, contact follow-up, assessment of compliance with treatment and appointments, and directly observed therapy (DOT) per Health and Safety Code 120175. The TB Control staff will also assist in facilitating timely and appropriate hospital discharge planning. **Since January 1, 1994, state law mandates that all TB patients have a health department-approved hospital discharge plan, *prior* to discharge**.

WHO MUST REPORT?

Anyone aware of a patient suspected to have, or confirmed with, active TB.

WHEN DO YOU REPORT?

A) When active TB is one of the primary differential diagnoses. This often occurs when:
   1. signs and symptoms of TB are present, and/or
   2. the patient has an abnormal chest x-ray consistent with TB, and/or
   3. the patient is placed on multidrug therapy for active TB or
B) When specimen smears are positive for acid fast bacilli (AFB).
C) When the patient has a positive *M. tuberculosis* or *M. bovis* culture.

HOW DO YOU REPORT?

The **Initial TB Case Report Form** is to be completed **in its entirety** and submitted to the health department. **Include copies of chest x-rays, preliminary AFB lab reports, and clinic notes**. TB Control staff will review this form and may return a call to the physician as needed.

By phone: (800) 722-4794 (weekdays 8:00 a.m.-5:00 p.m.)

By pager: (909) 677-7168 (after hours and holidays)

By FAX: (909) 381-8471 (please follow up a fax with a phone call during business hours)

The **Initial TB Case Report Form**, when submitted to TB Control, fulfills the legal requirement for any outpatient reporting. The process for discharge or transfer approval necessitates a different form. Please call (800) 722-4794 for further information about hospital discharge care plan submission/approval.

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PATIENT:_____
Last First MI
ADDRESS: _____

_____

Phone: (_____) Cell:(_____)

BIRTH DATE:_____/_____/_____ SEX ☐ M ☐ F

If patient is under 18, parent's name_____

EMPLOYER/SCHOOL: _____

Phone: (_____)_____

COUNTRY OF ORIGIN:_____

MONTH/YEAR ARRIVED IN US :_____/

FOREIGN TRAVEL_____

☐ White, non-Hispanic ☐ Black ☐ AM Ind/Eskimo

☐ Hispanic ☐ Asian/Pac. Is. (specify)_____

☐ Other_____

REPORTED BY:_____

PHYSICIAN: _____

PHONE: (_____)_____

INSURANCE/FUNDING: _____

☐ Pulmonary ☐ Extrapulmonary (site)_____ Date dx: ____/_____/_____

Skin Test:_____mm Date:_____

Quantiferon result: neg pos Date:_____

Chest X-Ray Date:_____☐ Cavitary ☐ Non-Cav.

Impression: _____

_____

If Pulmonary, check symptoms:

☐ Cough; Start Date _____ ☐ Night sweats/Fever

☐ Sputum production ☐ Hemoptysis

☐ Weight loss (# of lbs.)_____(# of mos.)_____ ☐ Fatigue

History of TB Treatment ☐ Yes ☐ No ☐ LTBI

If Yes: Where/when treated?_____

_____

If no symptoms, reason for evaluation:_____

Other medical conditions:_____

HIV: Date_____

☐ Positive ☐ Negative ☐ Recommended

Patient's current weight_____lbs/kg

Psychosocial History: smoker____ppd etoh use?_____

Drug use?_____IVDU?_____

Date/CD4 _____/_____ Date/VL _____/_____ Allergies_____

SPEC. #	SPEC. DATE	SPEC. TYPE	AFB SMR.	MTD/PCR	AFB CULT

MEDICATIONS	DOSE	START DATE
ISONIAZID		
RIFAMPIN/RBN		
ETHAMBUTOL		
PYRAZINAMIDE		
PYRIDOXINE (B6)		

LAB NAME: _____ HAART _____

PATH REPORT: _____

_____

ADDITIONAL COMMENTS: _____

_____

DATE REPORTED:_____INTAKE STAFF:_____