TUBERCULOSIS CASE / SUSPECT FOLLOW-UP REPORT

Hawaii State Department of Health
Tuberculosis Control Program

MAIL OR FAX TO:
Hawaii Tuberculosis Control Program
ATTN: TB REGISTRY DEPARTMENT
1700 Lanakila Avenue, Honolulu, HI 96817
FAX: 808-832-5624 PHONE: 808-832-5731

Name: ____ (LAST / FIRST / MIDDLE INITIAL)

Date of birth: _____/_____/__________ (MM / DD / YYYY)

Date last report received: _____/_____/__________ (MM / DD / YYYY)

Date current report requested: _____/_____/__________ (MM / DD / YYYY)

1. Please record all TB bacteriology results since last report:

DATE COLLECTED	**SPECIMEN TYPE & SITE** (E.G., SPUTUM, BRONCH WASH, TISSUE, PLEURAL FLUID, ETC.)	**SMEAR RESULT** IF POSITIVE, ENTER SMEAR COUNT (E.G., 1+, 2+, 3+, 4+)	**NUCLEIC ACID AMPLIFICATION** (E.G., MTD TEST or MTB-RNA, DIRECT)	**CULTURE** (CONFIRMED BY DNA PROBE)	**DRUG SUSCEPTIBILITY RESULTS** IF CULTURE POSITIVE FOR MTB, INDICATE DRUG RESISTANCE	**LAB**
/ /	Type: Site:	☐ NEG ☐ POS ____ ☐ PENDING	☐ NEG ☐ POS ☐ PEND ☐ INDET	☐ PEND ☐ NEG ☐ MTB COMPLEX ☐ NOT TB (SPECIFY ID): __________	☐ PEND ☐ PAN SUSCEPTIBLE ☐ RESISTANT TO: __________	☐ DLS ☐ Clinical
/ /	Type: Site:	☐ NEG ☐ POS ____ ☐ PENDING	☐ NEG ☐ POS ☐ PEND ☐ INDET	☐ PEND ☐ NEG ☐ MTB COMPLEX ☐ NOT TB (SPECIFY ID): __________	☐ PEND ☐ PAN SUSCEPTIBLE ☐ RESISTANT TO: __________	☐ DLS ☐ Clinical
/ /	Type: Site:	☐ NEG ☐ POS ____ ☐ PENDING	☐ NEG ☐ POS ☐ PEND ☐ INDET	☐ PEND ☐ NEG ☐ MTB COMPLEX ☐ NOT TB (SPECIFY ID): __________	☐ PEND ☐ PAN SUSCEPTIBLE ☐ RESISTANT TO: __________	☐ DLS ☐ Clinical

2. Please record the TB medication regimen:

Drug:	*Dosage:*	*Times/week:*	*Start date:*	*Stop date:*
Isoniazid	_______mg	_____	_____/_____/__________	_____/_____/__________
Rifampin	_______mg	_____	_____/_____/__________	_____/_____/__________
Pyrazinamide	_______mg	_____	_____/_____/__________	_____/_____/__________
Ethambutol	_______mg	_____	_____/_____/__________	_____/_____/__________
__________ (OTHER DRUG USED)	_______mg	_____	_____/_____/__________	_____/_____/__________
__________ (OTHER DRUG USED)	_______mg	_____	_____/_____/__________	_____/_____/__________

☐ TB medications not started, specify reason: ____

3. Patient on Directly Observed Therapy (DOT):

☐ No ☐ Yes ☐ Unknown

4. If TB regimen was stopped, specify reason:

☐ Completed full course of TB treatment
☐ Adverse effects of medicine
☐ Died before completing treatment
☐ Lost to follow-up
☐ Refused to complete treatment
☐ Other reason, please specify:

5. Date of chest x-ray or other chest imaging since last report: _____/_____/__________

Check one: ☐ Chest x-ray ☐ CT scan ☐ Other: ____________________

Check one: ☐ Abnormal ☐ Normal ☐ Not Done

If abnormal: Evidence of cavity: ☐ No ☐ Yes ☐ Unknown

Evidence of miliary TB: ☐ No ☐ Yes ☐ Unknown

If follow-up, check one: ☐ Stable ☐ Worsening ☐ Improving

6. Is the patient still under your supervision for TB?

☐ Yes
☐ No, specify reason:
☐ Completed TB treatment ☐ Delinquent
☐ Died ☐ Lost to follow-up
☐ Referred to different provider:

____________________ (NAME) ____________________ (PHONE)

☐ Other reason, please specify:

7. Date form completed: _____/_____/__________

Form completed by: ____

Name of physican: ______________________________ **Phone:** ________________

8. Additional notes / remarks: