1. Last Name First Name					MI		
2. Patient Number							of Health and Human Services on of Public Health
3. Date of							Section • TB Control Program
Birth		Month	Day	,	Year		_
4. Race □ 1. American Indian/Alaska Native □ 2. Asian □ 3. Black/African American □ 4. Native Hawaiia Other Pacific Islander □ 5. White □ 6. Unknow				awaiian/			g Record of losis Contacts
Ethnicity: Hispanic or Latino Origin? Yes No U				□ Unl			
5. Gender □ 1. Male □							
6. County of Residence						7. Date Case Reported to	Health Department//
8. Contact To: ☐ Pulmona ☐ Suspect				□Neg	□ Not Do	one Culture □ Pos □ Neg □ N	lot Done Specimen Source
Contact Information					Tests & Exposure		Treatment
Name:				TST # 1 Date placed:			
						•	3HP
DOB:	DOB: Age:				IGRA date: result: TST # 2 Date placed:		
				<u>_</u> n	mm reading:		Date started:
Race:		Gender:		10	IGRA date: result:		Date completed: If treatment not completed, why not:
Address:				T	ST#3 [om reading	Date placed:	1
Phone:				10	GRA date:	g: result:	adverse reaction died
County of Residence:					IIV: Date of HI\	neg pos declined	patient stopped lost to follow-up
Country of Birth:					Date of CXR:		provider decision
If not U.S., date of entry:				0	CXR result:		moved
						site name:	Comments:
Previous history of TB:					lours of ex	rposure: fied as a contact:	-
If yes, date:			_	F	Priority level:		
Previous history of LTBI: _				_	High Medium Low		
Date of TST/IGRA Was treatment completed					,	nptom screen:	
Trad trade t							_ Hemoptysis _ Appetite loss
						lained fatigue	Shortness of breath
					Chest		_ _ Unexplained weight loss
Contact	Informa	ition			Tests & Exposure		Treatment
Name:				Т	ST#1 [Date placed:	Treatment plan: INH RIF
					nm reading		3HP
DOB:		A a a :				result:	Other pes no
		Age:		'n	nm reading	Date placed: g:	Date started:
Race:		Gender:				result:	Date completed: If treatment not completed, why not:
Address:					ST#3 [nm reading	Date placed:	TB disease developed
Phone:					IGRA date: result:		adverse reaction died
County of Residence:							nationt stonged
Country of Birth:					IIV: Date of HI\	neg pos declined / test:	patient stopped lost to follow-up
					ate of HI	neg pos declined / test: R:	lost to follow-up provider decision
If not U.S., date of entry:					oate of HIN Date of CX CXR result	/ test: R: :	lost to follow-upprovider decisionmoved
					Date of HIND ate of CX CXR result Exposure s	/ test: R:	lost to follow-up provider decision
Previous history of TB:				C C E H	Date of HIND Date of CX CXR result Exposure solours of exposure of exposure solours of exposure solours of exposure solours of exposure of exposure of exposure of exposure of exposure solours of exposure so	/ test: R:	lost to follow-upprovider decisionmoved
Previous history of TB:				C C C C C C C C C C	Date of HIV Date of CX CXR result Exposure s Hours of ex Date identification	/ test: R: : site name: cposure: fied as a contact: el:	lost to follow-upprovider decisionmoved
Previous history of TB: If yes, date: Previous history of LTBI:	yes	no		C	Date of HIVD Date of CX CXR result Exposure sections of exposure sections of exposure sections of exposure identification of the High	/ test: R: site name: kposure: fied as a contact: el: Medium Low	lost to follow-upprovider decisionmoved
Previous history of TB:	yes _	no reading:		C	Date of HIVD Date of CX CXR result Exposure sections of exposure sections of exposur	/ test: R:	lost to follow-up provider decision moved Comments:
Previous history of TB: If yes, date: Previous history of LTBI: _ Date of TST/IGRA	yes _	no reading:		C	Date of HINDate of CXCXR result exposure solurs of exposure identification of the High control of the High	/ test: R:	lost to follow-upprovider decisionmoved

_ Chest pain

___ Unexplained weight loss

Contact Information	Tests & Exposure	Treatment
Name:	TST # 1 Date placed: mm reading:	Treatment plan: INH RIF 3HP
	IGRA date: result:	Other
DOB: Age:	TST # 2 Date placed:mm reading:	Declined treatment: yes no Date started:
Race: Gender:	IGRA date: result:	Date started:
Address:	TST # 3 Date placed:mm reading:	If treatment not completed, why not: TB disease developed
Phone:	IGRA date: result:	adverse reaction died
County of Residence:	HIV:negposdeclined Date of HIV test:	patient stopped
Country of Birth:	Date of CXR:	provider decision moved
If not U.S., date of entry:	CXR result:	
Previous history of TB: yes no	Exposure site name: Hours of exposure:	Comments:
If yes, date:	Date identified as a contact:	
Previous history of LTBI:yesno	Priority level: High Medium Low	
Date of TST/IGRA MM reading:	Figit Mediatit Low	
Was treatment completed:yes no	Date of symptom screen:	· · · · · · · · · · · · · · · · · · ·
was treatment completedyesno		Hemoptysis
		Appetite loss
		Shortness of breath
	Chest pain	Unexplained weight loss
Contact Information	Tests & Exposure	Treatment
Contact Information Name:	Tests & Exposure TST # 1 Date placed: mm reading:	Treatment
	TST # 1 Date placed: mm reading:	Treatment plan: INH RIF 3HP
	TST # 1 Date placed: mm reading: IGRA date: result: TST # 2 Date placed:	Treatment plan: INH RIF 3HP Other Declined treatment: yes no
Name:	TST # 1 Date placed: mm reading: IGRA date: result: TST # 2 Date placed: mm reading:	Treatment plan: INH RIF 3HP Other Peclined treatment: yes no Date started: Date completed: Page 1.00
Name: DOB: Age:	TST # 1 Date placed:	Treatment plan: INH RIF 3HP Other Declined treatment: yes no Date started: Date completed: If treatment not completed, why not: TB disease developed
DOB: Age: Race: Gender:	TST # 1 Date placed:	Treatment plan: INH RIF 3HP Other Declined treatment: yes no Date started: Date completed: If treatment not completed, why not: TB disease developed adverse reaction died
Name: DOB: Age: Race: Gender: Address:	TST # 1 Date placed:	Treatment plan: INH RIF 3HP Other Declined treatment: yes no Date started: Date completed: If treatment not completed, why not: TB disease developed
Name: DOB: Age: Race: Gender: Address: Phone:	TST # 1 Date placed:	Treatment plan: INH RIF 3HP Other Declined treatment: yes no Date started: Date completed: If treatment not completed, why not: TB disease developed
Name: DOB: Age: Race: Gender: Address: Phone: County of Residence:	TST # 1 Date placed:	Treatment plan: INH RIF 3HP Other Declined treatment: yes no Date started: Date completed: If treatment not completed, why not: TB disease developed adverse reaction died patient stopped lost to follow-up provider decision moved
Name: DOB: Age: Race: Gender: Address: Phone: County of Residence: Country of Birth: If not U.S., date of entry:	TST # 1 Date placed:	Treatment plan: INH RIF 3HP Other Declined treatment: yes no Date started: Date completed: If treatment not completed, why not: TB disease developed
Name: DOB: Age: Race: Gender: Address: Phone: County of Residence: Country of Birth: If not U.S., date of entry: Previous history of TB:yes no	TST # 1 Date placed:	Treatment plan: INH RIF 3HP Other Declined treatment: yes no Date started: Date completed: If treatment not completed, why not: TB disease developed adverse reaction died patient stopped lost to follow-up provider decision moved
Name: DOB: Age: Race: Gender: Address: Phone: County of Residence: Country of Birth: If not U.S., date of entry: Previous history of TB: yes no If yes, date:	TST # 1 Date placed:	Treatment plan: INH RIF 3HP Other Declined treatment: yes no Date started: Date completed: If treatment not completed, why not: TB disease developed adverse reaction died patient stopped lost to follow-up provider decision moved
Name: DOB: Age: Race: Gender: Address: Phone: County of Residence: Country of Birth: If not U.S., date of entry: Previous history of TB:yes no If yes, date: Previous history of LTBI:yes no	TST # 1 Date placed:	Treatment plan:INHRIF3HPOther Declined treatment:yesno Date started: Date completed: If treatment not completed, why not:TB disease developedadverse reactiondiedpatient stoppedlost to follow-upprovider decisionmoved
DOB: Age: Race: Gender: Address: Phone: County of Residence: Country of Birth: If not U.S., date of entry: Previous history of TB:yes no If yes, date: Previous history of LTBI:yes no Date of TST/IGRA MM reading:	TST # 1 Date placed:	Treatment plan: INH RIF 3HP Other Declined treatment: yes no Date started: Date completed: If treatment not completed, why not: TB disease developed adverse reaction died patient stopped lost to follow-up provider decision moved Comments:
Name: DOB: Age: Race: Gender: Address: Phone: County of Residence: Country of Birth: If not U.S., date of entry: Previous history of TB:yes no If yes, date: Previous history of LTBI:yes no	TST # 1 Date placed:	Treatment plan: INH RIF 3HP Other Declined treatment: yes no Date started: Date completed: If treatment not completed, why not: TB disease developed adverse reaction died patient stopped lost to follow-up provider decision moved Comments:
DOB: Age: Race: Gender: Address: Phone: County of Residence: Country of Birth: If not U.S., date of entry: Previous history of TB:yes no If yes, date: Previous history of LTBI:yes no Date of TST/IGRA MM reading:	TST # 1 Date placed:	Treatment plan: INH RIF 3HP Other Declined treatment: yes no Date started: Date completed: If treatment not completed, why not: TB disease developed adverse reaction died patient stopped lost to follow-up provider decision moved Comments: Hemoptysis Appetite loss
DOB: Age: Race: Gender: Address: Phone: County of Residence: Country of Birth: If not U.S., date of entry: Previous history of TB:yes no If yes, date: Previous history of LTBI:yes no Date of TST/IGRA MM reading:	TST # 1 Date placed:	Treatment plan: INH RIF 3HP Other Declined treatment: yes no Date started: Date completed: If treatment not completed, why not: TB disease developed adverse reaction died patient stopped lost to follow-up provider decision moved Comments: