Interjurisdictional Tuberculosis Notification

Referring Jurisdiction_city_____county_____state_____ Date sent _____/_____/_____

Contact person_____ Phone ( ) _____ FAX ( )_____

☐ Verified case State reporting to CDC:_____ RVCT#_____(attach RVCT) ☐ Not reported_____

☐ Suspect case ☐ Close contact ☐ Reactor (LTBI) ☐ Convertor (LTBI) ☐ Source case investigation ☐ A/B Classified Immigrant

Patient name_____ Sex ☐ M ☐ F
Last First Middle

AKA_____

Date of birth _____/_____/_____ Interpreter needed? ☐ No ☐ Yes, specify language_____

New address _____ Hispanic ☐ No ☐ Yes
Number/Street/Apt.

Race ☐ White ☐ Black ☐ Asian
☐ Am.Indian/Nat.Alaskan.
☐ Other:_____

_____
City/State/ZipCode

New telephone ( )_____ Date of expected arrival _____/_____/_____

New health provider ☐ Unknown ☐ Known (name, address, phone)_____

Emergency contact: Name_____ Phone ( )_____

Relationship_____

Clinical information for ☐ this referred case/suspect ☐ index case for this contact ☐ not applicable

Date of Collection	Specimen type	Smear	Culture	Susceptibility	Chest X-ray	Other

Site(s) of disease: ☐ Pulmonary ☐ Other(s) specify all_____

Date 1st negative smear _____/_____/_____ ☐ Not yet Date 1st negative culture _____/_____/_____ ☐ Not yet

TB skin test #1:Date _____/_____/_____ Result _____mm TB skin test #2: Date _____/_____/_____ Result_____mm

Contact/LTBI Information **TB Skin test** ☐ Not Done

TST #1 Date _____/_____/_____ Result _____mm TST#2 Date _____/_____/_____ Result_____mm

CXR ☐ Not Done Date _____/_____/_____ ☐ Normal ☐ Other:_____

Last known exposure to index case _____/_____/_____ Place/intensity of exposure:_____

Medications ☐ this referred case/suspect ☐ this referred contact/LTBI

Drug	Dose	Start date	Stop date

Planned completion date _____/_____/_____

DOT ☐ No ☐ Yes: start date _____/_____/_____

☐ Daily ☐ 1x W ☐ 2x W ☐ 3x W

Last DOT Date _____/_____/_____

Adherence problems/significant drug side effects:

_____

_____

_____

Patient given _____ days of medication

Comments_____

_____

_____

For non-Class 3/5 referrals indicate if: ☐ Follow-up requested ☐ No follow-up requested