INITIAL REPORT ON PATIENT WITH TUBERCULOSIS

IDPH Illinois Department of Public Health

Physician:	**Address:**	**Date:**
City/State/Zip:	Phone:	Fax:

New TB Case: ❒ No ❒ Yes Old Case Reactivated: ❒ No ❒ Yes

Patient Name: _____ Date of Birth: ____ _____ _____

Address: _____ City: _____ State: _____ County: _____

Telephone: _____ Sex: ❒ Male ❒ Female Hispanic: ❒ No ❒ Yes

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

MEDICAL INFORMATION:

TST Date: _____ Result: _____mm TB Site: _____

Chest X-Ray Date: _____ Comments: _____

❒ Normal ❒ Abnormal ❒ Cavitary ❒ Non-cavitary ❒ Stable ❒ Worsening ❒ Improving

CT Scan Date: _____ Comments: _____

❒ Normal ❒ Abnormal ❒ Cavitary ❒ Non-cavitary ❒ Stable ❒ Worsening ❒ Improving

BACTERIOLOGY

HIV Test Date:

_____

Result: _____

Date of Collection	Specimen type	Smear	Culture	MTB/NTM

ALT/SGPT Date: _____ Result: _____ Visual Acuity Date: _____ Result: _____

AST/SGOT Date: _____ Result: _____ Hearing Test Date: _____ Result: _____

MEDICATIONS:		**DATE STARTED:**	**COMMENTS:**
ISONIAZID	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
RIFAMPIN	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
PYRAZINAMIDE	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
ETHAMBUTOL	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
PYRIDOXINE	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
_____	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____
_____	_____ MG PO _____ X WEEK	_____ (____ doses given)	_____

Person Completing Form: _____ **Date Completed:** _____