MEDICAL CASE REVIEW

Date: _____/_____/_____	**LHD:**	**State Case Number:**

Patient Name: ____ **Date of Birth**: _____ /_____ /_____

Occupation: ____ **Last Date Worked**: _____/_____/_____

Sex: ❒Male ❒Female **Hispanic:** ❒No ❒Yes **Race:** ❒White ❒Black ❒Asian ❒Am. Indian/Nat. Alaskan ❒Other _______

US Born: ❒Yes ❒No **If no, US Date of Arrival**: _____/_____/_____ **Country of Birth:** ______________________

Contact to Known Case? ❒Yes ❒No **If case is <18, source identified:** ________________________

DIAGNOSTIC INFORMATION:

Date of Initial TB Diagnosis/Suspicion of TB: _____/_____/_____ **Date of Referral to LHD: _____/_____/_____**

Diagnosed: ❒Hospital ❒Physician's Office ❒Health Dept. ❒Other: ____________________

Status at Diagnosis: ❒Alive ❒ Dead (date died) _____/_____/_____

Primary Reason for Evaluation: ❒Contact Investigation ❒Targeted Testing ❒HCW ❒Employment Screening ❒Immigration Exam ❒Incidental Abnormal CXR/CT ❒Incidental Lab Result ❒Other: ___________________________________

Date of Symptom Onset: _____/_____/_____ **Symptoms**: ❒Cough ❒Chest Pain ❒Hemoptysis ❒Fever

❒Fatigue ❒SOB ❒Night Sweats ❒Weight Loss of _____lbs ❒Other: _______________________

TST Date: _____/_____/_____**Result**: ________**mm** **IGRA Date: _____/_____/_____ Result: ___________**

Chest X-Ray Date: _____/_____/_____ **Result**: ❒Normal ❒Abnormal

If Abnormal, ❒Cavitary ❒Noncavitary

If Noncavitary, ❒Consistent with TB ❒Inconsistent with TB

CT Scan Date: _____/_____/_____ **Result**: ❒Normal ❒Abnormal

If Abnormal, ❒Cavitary ❒Noncavitary

If Noncavitary, ❒Consistent with TB ❒Inconsistent with TB

Site of Disease: ❒Pulmonary ❒Both Pulmonary and Extrapulmonary ❒Extrapulmonary - Ruled out PTB ❒Yes ❒No

CO-MORBID MEDICAL:

Patient History of Liver Dysfunction? ❒No ❒Yes If yes, explain: ______________________________________

❒Diabetes Mellitus ❒Silicosis ❒End Stage Renal Disease ❒Chronic Liver Disease

❒Hepatitis B ❒Hepatitis C ❒Post Organ Transplant ❒Cancer (site) _______

❒Tumor Necrosis factor alpha (TNF) antagonists ❒Other: _________________

Medical Complications: ❒Yes ❒No If yes, explain: ____

Allergies: ❒Yes ❒No If yes, explain: ____

LABORATORY INFORMATION:

Fluid Specimens	Date(s) Collected	SMEAR				CULTURE			
		Positive	Negative	Pending	Not Done	Positive	Negative	Pending	Not Done
Intial Sputum	____/____/____	☐	☐	☐	☐	☐	☐	☐	☐
	____/____/____	☐	☐	☐	☐	☐	☐	☐	☐
	____/____/____	☐	☐	☐	☐	☐	☐	☐	☐
	____/____/____	☐	☐	☐	☐	☐	☐	☐	☐
Bronchial	____/____/____	☐	☐	☐	☐	☐	☐	☐	☐
Wash	____/____/____	☐	☐	☐	☐	☐	☐	☐	☐
Gastric	____/____/____	☐	☐	☐	☐	☐	☐	☐	☐
Aspirate	____/____/____	☐	☐	☐	☐	☐	☐	☐	☐
Pleural	____/____/____	☐	☐	☐	☐	☐	☐	☐	☐
Fluid	____/____/____	☐	☐	☐	☐	☐	☐	☐	☐
CSF	____/____/____	☐	☐	☐	☐	☐	☐	☐	☐
Urine	____/____/____	☐	☐	☐	☐	☐	☐	☐	☐
Other	____/____/____	☐	☐	☐	☐	☐	☐	☐	☐
__________	____/____/____	☐	☐	☐	☐	☐	☐	☐	☐

Sputum Culture Conversion: ❐ Documented ❐ Not Documented ❐ Not Applicable

If Documented: Date of Conversion _____/_____/_____ Number of days to culture conversion: _________

If NOT Documented: ❐ Specimen Not Collected ❐ Other: ______________________________________

Specimen Sent for Genotyping: ❐ Yes ❐ No If no, why? ____

Drug Susceptibility Testing: ❐ Yes ❐ No If no, why? ____

MEDICATIONS:		**DATE STARTED:**	**DRUG SUSCEPTIBILITY:**
ISONIAZID	_______ MG PO _______ X WEEK	__________ (____ doses given)	❐ No ❐ Yes ❐ Sensitive ❐ Resistant
RIFAMPIN	_______ MG PO _______ X WEEK	__________ (____ doses given)	❐ No ❐ Yes ❐ Sensitive ❐ Resistant
PYRAZINAMIDE	_______ MG PO _______ X WEEK	__________ (____ doses given)	❐ No ❐ Yes ❐ Sensitive ❐ Resistant
ETHAMBUTOL	_______ MG PO _______ X WEEK	__________ (____ doses given)	❐ No ❐ Yes ❐ Sensitive ❐ Resistant
PYRIDOXINE	_______ MG PO _______ X WEEK	__________ (____ doses given)	❐ No ❐ Yes ❐ Sensitive ❐ Resistant
______________	_______ MG PO _______ X WEEK	__________ (____ doses given)	❐ No ❐ Yes ❐ Sensitive ❐ Resistant

Is Therapy Directly Observed? ❐ Yes ❐ No If no, why: ____

If yes, what methods were used? ❐ In Person ❐ Multimedia (Specify Type): ___________________ ❐ Both

Treatment interruptions? ❐ Yes ❐ No Date stopped: _____/_____/_____

Medical/adverse reactions: ❐ Yes ❐ No Specify: ____

Liver Enzymes Elevated: ❐ Yes ❐ No Specify: ____

Patient Non-adherence: ❐ Yes ❐ No Specify: ____

Provider Reasons: ❐ Yes ❐ No Specify: ____

Treatment Stop Date: _____/_____/______ Treatment >12 months: ❐ Yes ❐ No If yes, why? _________________

Did Patient Complete Treatment in 365 Days? ❐ Yes ❐ No If not, why? ____________________________

TB RISK FACTORS:

Previous diagnosis of TB disease? ❒Yes ❒No If yes, year _____ Was treatment completed? ❒Yes ❒No

Previous treatment for LTBI? ❒Yes ❒No If yes, year _____ Was treatment completed? ❒Yes ❒No

Homeless in the past year? ❒Yes ❒No

Resident of correctional facility at diagnosis? ❒Yes ❒No If yes, where: ____

History of incarceration? ❒Yes ❒No If yes, year _____ Where: ___________________________

Resident of long-term care facility? ❒Yes ❒No If yes, where: ____

Excessive alcohol use in past year? ❒Yes ❒No

IV drug use in the past year? ❒Yes ❒No If yes, what____

Non-IV drug use in past year? ❒Yes ❒No

Currently smoking tobacco? ❒Yes ❒No

Travel outside of US longer than 30 days? ❒Yes ❒No If yes, when and where: _______________________________

Previous contact to an infectious patient? ❒Yes ❒No If yes, year _____ Case Number:_________________________

BARRIERS TO ADHERENCE:

❒Homelessness ❒Unemployment ❒Domestic violence/Abuse

❒Low Literacy ❒Language Barrier ❒Cultural Barriers

❒Depression ❒Suicidal/homicidal thoughts ❒Paranoia/Defiant/Erratic behavior

❒Uncooperative ❒Does not follow isolation ❒Misses clinical appointments

❒Misses DOT appointments ❒Reluctant to identify contacts ❒Inadequate Housing

❒Inadequate nutrition ❒Inadequate income ❒Inadequate transportation

❒Inadequate healthcare/insurance ❒Alcohol Use ❒Drug use Specify: ____________

CLOSURE: **Date of Case Closure: _____/_____/_____**

Reason: ❒Not TB ❒Completed Treatment ❒Lost to Follow-Up ❒Refused/Noncompliant ❒Adverse Treatment Event ❒Died: Cause of Death ______________________

Did Patient Move? ❒No ❒Yes If yes, where _________________

Date Case Information Transferred: _____/_____/_____

CONTACT INVESTIGATION:

Was a contact investigation conducted on this case? ❒Yes ❒No If not, why? ______________________________

Contacts	Household Adults	Children	Work	HCWs	Social	Total
Identified						
Refused Evaluation						
Evaluated						
US Born						
Foreign Born						
TST/IGRA Positive						
Active Disease						
Started LTBI Treatment						
Started Window Prophylaxis						
Refused LTBI Treatment						
Currently on LTBI Treatment						
Discontinued LTBI Treatment						
Lost to Follow-Up						
Died Before Completed LTBI Treatment						
Completed LTBI Treatment						

Identify all barriers experienced during the management of the case and CI whether you were able to overcome the barrier or not. Write strategies (if any) that you used in the appropriate column (whether effective or ineffective). For checked barriers with no strategies, we will assume the barrier was unaddressed.

Contact Investigation Barriers	Effective Strategies	Ineffective Strategies
☐ Language		
☐ Culture/Religion		
☐ Uncooperative Patient		
☐ Uncooperative Contacts		
☐ Known Previous Exposure		
☐ Patient Education		
☐ LHD Org. Capacity		
☐ LHD Staff Training		
☐ LHD Resources		
☐ Testing Supplies		
☐ Other: ______________________		

CASE MANAGEMENT: CLINICAL

Case Management Barriers	Effective Strategies	Ineffective Strategies
☐ Medication Interactions		
☐ Medical Management		
☐ DOT		
☐ Lab Specimen Collection		
☐ Unspecified Lab Results		
☐ Referring/Managing Physician		
☐ Co-Management (HIV, Diabetes, Mental Illness, Hepatitis, etc.)		
☐ Previous Diagnosis of TB/LTBI		
☐ Did Not Finish T/LTBI Treatment		
☐ In Genotype Cluster		
☐ LHD Staff Knowledge/Training		
☐ Partnerships With Other Organizations		
☐ Other: ______________________		

CASE MANAGEMENT: SOCIAL

Case Management Barriers	Effective Strategies	Ineffective Strategies
☐ Language		
☐ Culture		
☐ Religion		
☐ Injection Drug User		
☐ Non-injection Drug User		
☐ Alcoholism		
☐ Patient Cooperation		
☐ Family Cooperation/Support		
☐ Literacy		
☐ Other: ______________________		

CASE MANAGEMENT: ECONOMICAL

Case Management Barriers	Effective Strategies	Ineffective Strategies
☐ Transportation		
☐ Unemployed/Employment Security		
☐ Homelessness/Shelter Security		
☐ Food Security		
☐ Financial Stability		
☐ Uninsured/Underinsured		
☐ Other: ______________________		

ADDITIONAL COMMENTS:

____

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____

RECOMMENDATIONS:

____

____

____

____

Person Completing Form: _______________________________________ **Date Completed:** ____/____/____