TUBERCULOSIS SUSPECT CASE REPORT

County of San Diego

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DIRECTOR

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PUBLIC HEALTH SERVICES
TUBERCULOSIS CONTROL BRANCH
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PUBLIC HEALTH OFFICER

TUBERCULOSIS CONTROL

Reporting of all patients with confirmed or suspect tuberculosis (TB) is mandated by state Health and Safety Codes Div. 4, Chapter 5 and Admin, Codes, Title 17, Chapter 4, Section 2500 and must be done within one day of diagnosis.

WHY DO YOU REPORT?

Because it is the law! The health department performs many vital functions to ensure public health and safety, including case management, contact follow-up, assessment of compliance with treatment and appointments, and directly observed therapy (DOT). The TB Control staff will also assist in facilitating timely and appropriate discharge planning. Since January 1, 1994, state law mandates that all TB patients have a health department-approved discharge plan, prior to discharge.

WHO MUST REPORT?

Anyone aware of a patient suspected to have, or confirmed with, active TB.

WHEN DO YOU REPORT?

A) When active TB is one of the primary differential diagnoses. This often occurs when:
   1. signs and symptoms of TB are present, and/or
   2. the patient has an abnormal chest x-ray consistent with TB, and/or
   3. the patient is placed on multidrug therapy for active TB or
B) When specimen smears are positive for acid fast bacilli (AFB).
C) When the patient has a positive M. tuberculosis or M. bovis culture.

HOW DO YOU REPORT?

The form on the other side is to be completed in its entirety and submitted to the health department. TB Control staff will review this form and may return a call to the physician as needed.

By phone: (619) 692-8610

By cell phone: (619) 540-0194 (weekdays 8:00 a.m.-5:00 p.m., weekends/holidays 8:00 a.m.-5:00 p.m.)

By FAX: (619) 692-5516

This form, when submitted to TB Control, fulfills the legal requirement for reporting. The process for discharge or transfer approval necessitates a different form. Please call (619) 692-8610 for further information about discharge care plan submission/approval.

HHSA: TB-216a (10/09) County of San Diego Health and Human Services Agency
TUBERCULOSIS SUSPECT CASE REPORT

PATIENT: ____________________  LAST  __________  ______  MI

ADDRESS: _______________________________________________________

Phone: (_____) ___________________  Cell: (_____) ___________________

BIRTH DATE: / /       SEX □ M  □ F

SSN#  / / ________________________

EMPLOYER/SCHOOL: _____________________________________________

Phone: (_____) ___________________

INSURANCE/FUNDING: ___________________________________________

□ White, non-Hispanic  □ Black  □ AM Ind/Eskimo

□ Hispanic  □ Asian/Pac. Is. (specify) _____________________________

□ Other: _______________________________________________________

Field PHN: _____________________________________________________

REPORTED BY: _________________________________________________

PHONE: (_____) ___________________

Email: __________________________________________________________

DIAGNOSING FACILITY: __________________________________________

(A:  __________) _______________________________________________

MEDICAL RECORD# _____________________________________________

Patient hospitalized at diagnosis?  □ Yes  □ No

Patient currently hospitalized:  □ Yes  □ No

Paramedics notified?  □ Yes  □ No  □ N/A

□ PHYSICIAN: ___________________________________________________

Phone: (_____) ___________________

Email: __________________________________________________________

□ PHYSICIAN: ___________________________________________________

Phone: (_____) ___________________

Email: __________________________________________________________

Pharmacy: _______________________________________________________

□ Pulmonary  □ Extrapulmonary (site) ____________________________  Date dx:

Skin Test _______ mm  □ Negative  Chest X-Ray Date: ___________  □ Cavity  □ Non-Cav.

Date read: ___________  □ Not done  Impression: ______________________

QFT result: □ neg  □ pos _____ IU/mL Date: __________________________

□ indet  CT Date: __________

If Pulmonary, check symptoms: _______________________________________

□ Cough; Start Date ___________  □ Night sweats/Fever

□ Sputum production  □ Hemoptysis

□ Weight loss (# of lbs.) _______ (# of mos.) _______  □ Fatigue

If asx, reason for evaluation: _________________________________________

Other medical conditions: ___________________________________________

Date/HIV: ___________  □ Positive  □ Negative

Current weight _________ lbs. _________ kg.  Ht. _________

□ Recommended  Psychosocial History? _____________________________

Date/CD4 ___________ /   Date/VL ___________ /   Allergies

SPEC. #  SPEC. DATE  SPEC. TYPE  AFB SMR.  MTD/PCR  AFB CULT

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LAB NAME: _________________________________________________________

PATH REPORT: _____________________________________________________

HAART ____________________________________________________________

□ NOTIFIED PROVIDER OF DOT/PH INVOLVEMENT

ADDITIONAL COMMENTS: _____________________________________________

DATE REPORTED: ___________  INTAKE NURSE: ___________  PHONE: ___________

County of San Diego Health and Human Services Agency