TUBERCULOSIS SUSPECT CASE REPORT

County of San Diego

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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.

TUBERCULOSIS SUSPECT CASE REPORT

Nsg Station/Ph# _____
Pt. Room# _____
C.M. Name _____
Ph# _____

❒ CalREDIE # _____

PATIENT: _____
Last First MI
ADDRESS: _____
_____
Phone: (_____) _____ Cell: (_____) _____
BIRTH DATE: _____/_____/_____ SEX ☐ M ☐ F
SSN# _____/_____/_____
EMPLOYER/SCHOOL: _____
Phone: (_____) _____
EMERGENCY CONTACT: _____
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: _____ ☐ Cavitary ☐ 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 **History of TB Treatment** ☐ Yes ☐ No ☐ LTBI
☐ Weight loss (# of lbs.) _____ (# of mos.) _____ ☐ Fatigue If Yes: Where/when treated? _____
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

MEDICATIONS	DOSE	START DATE
ISONIAZID		
RIFAMPIN/RBN		
ETHAMBUTOL		
PYRAZINAMIDE		
PYRIDOXINE (B6)		

LAB NAME: _____
PATH REPORT: _____ HAART _____
_____ ☐ NOTIFIED PROVIDER OF DOT/PH INVOLVEMENT
ADDITIONAL COMMENTS: _____
_____ DATE: _____ AST/ALT: _____
DATE REPORTED: _____ INTAKE NURSE: _____ PHONE: _____