**Grayed areas for TB Control use only*

❒ WebCMR # _____

TUBERCULOSIS SUSPECT CASE REPORT

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

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: _____

REPORTED BY:_____
PHONE: (_____) _____
DIAGNOSING FACILITY: _____
(A:) _____
MEDICAL RECORD# _____
Patient hospitalized at diagnosis? ☐ Yes ☐ No
Patient currently hospitalized: ☐ Yes ☐ No
Paramedics notified? ☐ Yes ☐ No ☐ N/A
☐ PHYSICIAN: _____
Phone: (_____) _____
☐ PHYSICIAN: _____
Phone: (_____) _____

Field PHN: _____

☐ 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:_____
Psychosocial History? _____ Current weight _____lbs. _____ kg. Ht. _____
Date/HIV: _____ ☐ Pos ☐ Neg ☐ Rec BMI _____ Adj wt _____
Date/CD4 _____/_____ Date/VL _____/_____ Antiretrovirals: _____

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

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

LAB NAME: _____ REF LAB: _____ ALLERGIES: _____
PATH REPORT: _____ HCG ☐ ☐ N/A

_____

ADDITIONAL COMMENTS: _____

_____ DATE: _____ AST/ALT: _____

DATE REPORTED: _____ INTAKE NURSE: _____ DATE: _____

TUBERCULOSIS SUSPECT CASE REPORT

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
PUBLIC HEALTH SERVICES
TUBERCULOSIS CONTROL BRANCH
3851 ROSECRANS STREET, MAIL STOP P-576
SAN DIEGO, CA 92110-3134
(619) 692-5565 • FAX (619) 692-5650

WILMA J. WOOTEN, M.D., M.P.H.
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 opposite side may be completed and faxed to the Health Department. Supporting medical records with this information will need to be submitted. TB Control staff will review and may contact the physician as needed.

By phone: Weekdays/non-holidays (619) 692-8610

Weekends/County holidays (619) 540-0194

By FAX: (619) 692-5516

This form, when submitted to TB Control along with medical records, 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.