CONFIRMED OR SUSPECTED REPORT OF TUBERCULOSIS DISEASE

Department of Public Health & Human Services
TB Program Cogswell Building, Room C-216
1400 Broadway, Helena, MT, 59620
Phone: 406-444-0273; Fax: 1-800-616-7460

Today's Date: _____
Submitted By: _____
Phone: _____
Email: _____

Patient Name: _____ Age: _____ DOB: _____
City: _____ County: _____ State: _____ Zip Code: _____

Country of Birth: U.S. born or born abroad to a parent who was a U.S. citizen ( ) Yes ( ) No
If No, specify Country of Birth: _____ Arrived in U.S. MM/YYYY: _____
Immigrant Status at first entry to the U.S.
( ) Immigrant Visa ( ) Tourist Visa ( ) Asylee or Parolee
( ) Student Visa ( ) Family/Fiancé Visa ( ) Other Immigration Status
( ) Employment Visa ( ) Refugee ( ) Unknown
Pediatric TB patient (<15 yrs.): ( ) Yes ( ) No
Patient lived outside U.S. for >2 months ( ) Yes ( ) No If Yes, list countries: _____
Country of birth Guardian 1, specify: _____ Guardian 2, specify: _____

Sex at Birth:
( ) Female
( ) Male

Race:
( ) White
( ) American Indian or Alaska Native
( ) Black or African American
( ) Asian, specify: _____
( ) Native Hawaiian or Other Pacific Islander, specify: _____

Ethnicity:
( ) Hispanic
( ) Non-Hispanic

Occupation: Check all that apply within the past 24 months
( ) Health Care Worker
( ) Migratory Agricultural Worker
( ) Correctional Worker
( ) Other _____
( ) Not seeking employment (student, homemaker, disabled)
( ) Retired
( ) Not employed past 24 months

Resident of Correctional Facility: ( ) Yes ( ) No Facility Name: _____
If Yes, under custody of Immigration and Customs Enforcement? ( ) Yes ( ) No

Resident of Long-term Care Facility: ( ) Yes ( ) No Facility Name: _____
( ) Nursing Home ( ) Residential Facility ( ) Alcohol or Drug Treatment Facility
( ) Hospital-Based Facility ( ) Mental Health Residential Facility ( ) Other: _____

Homeless within the last year: ( ) Yes ( ) No If in shelter, name: _____

Injecting Drug use within Past Year: ( ) Yes ( ) No
Non-injecting Drug use within Past Year: ( ) Yes ( ) No
Excess Alcohol Use within Past Year: ( ) Yes ( ) No

Additional TB risk factors (select all that apply)
( ) Contact of MDR-TB Patient (2 years or less)
Name of case (if known): _____
( ) Missed Contact (2 years or less)
Name of case (if known): _____
( ) TNF-α Antagonist Therapy
( ) Diabetes Mellitus
( ) HIV/AIDS
( ) None
( ) Contact of Infectious TB Patient (2 years or less)
Name of case (if known): _____
( ) Incomplete LTBI Therapy
( ) Post-organ Transplantation
( ) End-Stage Renal Disease
( ) Liver Disease, specify _____
( ) Immunosuppression (not HIV/AIDS)
( ) Other, specify _____

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Patient Name:

Diagnosis Date: _____ Date TB first suspected: _____
Site, select all that apply: ( ) Pulmonary ( ) Pleural ( ) Bone/Joint ( ) Lymph, specify:_____
( ) Other, specify:_____
Previous diagnosis of TB disease: ( ) Yes ( ) No List year of previous diagnosis: _____
Status at TB diagnosis: ( ) Alive ( ) Dead Date of death: _____
If Dead, was TB a cause of death: ( ) Yes ( ) No

Primary Reason Evaluated for TB:

( ) TB Symptoms ( ) Abnormal Chest Radiograph ( ) Contact Investigation
( ) Targeted Testing ( ) Health Care Worker ( ) Employment/Administrative Testing
( ) Immigration Medical Exam ( ) Incidental Lab Result ( ) Other:_____

Brief Clinical History:_____

_____

_____

_____

1. Tuberculin Skin Test Results: Date: _____ mm of Induration: _____
2. HIV Status at time of diagnosis: Date: _____ ( ) Positive ( ) Negative ( ) Not Offered ( ) Refused
3. Interferon Gamma Release Assay for *Mycobacterium tuberculosis* at diagnosis:
   Date:_____ Results: _____
4. Initial X-Ray Results: Date: _____ Results:_____
   Attach X-ray report Evidence of a cavity: ( ) Yes ( ) No Evidence of miliary TB: ( ) Yes ( ) No
5. Initial Chest CT scan: Date: _____ Results:_____
   Attach CT report Evidence of a cavity: ( ) Yes ( ) No Evidence of miliary TB: ( ) Yes ( ) No
6. Bacteriological Results: **If state lab is not used, attach lab results. If state lab is used, results are on file.**
7. Smear/Pathology/Cytology of tissue and other body fluids:
   Attach Report(s) Date: _____ Results:_____

Date Therapy Started: _____
Initial Medication Regimen: ( ) INH ( ) RIF ( ) PZA ( ) EMB ( ) Other _____

DOT Plan: (dose, freq, location) _____

_____

_____

_____

Attending Physician: _____ **Phone:**_____

Public Health Case Manager: _____ **Phone:**_____