



**DEPARTMENT OF HEALTH
REPORT OF TUBERCULOSIS**

State Form 14058 (R5/11-00)

INDIANA STATE DEPARTMENT OF HEALTH
2 North Meridian Street, Section 6-A
Indianapolis, IN 46204
(317) 233-7420

TB Law: Every suspected and verified case of tuberculosis disease must be reported to the local health officer within 72 hours (from probable diagnosis) in accordance with 410 IAC 1-2.1

<p>1. Patient name (Last, First, MI): _____</p> <p>2. Address _____ _____ _____ City _____ Within city limits: Yes <input type="checkbox"/> No <input type="checkbox"/> Phone (____) _____ County _____ Zip Code _____</p> <p>3. Date of birth ____/____/____ 4. At time of report: Alive <input type="checkbox"/> Dead <input type="checkbox"/></p> <p>5. Age _____ 6. Sex: Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p>7. Occupation _____ Place of Employment/School _____</p>	<p style="text-align: center;">FOR LOCAL HEALTH DEPARTMENT USE ONLY</p> <p>Date received at local health department _____</p> <p>Received by _____</p> <p>Phone ____ (____) _____</p>
<p>8. Race: Check all that apply White <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/></p> <p>9. Ethnic origin: Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Multicultural <input type="checkbox"/></p> <p>10. Born in U.S. Yes <input type="checkbox"/> No <input type="checkbox"/> If "No," what is country of origin _____ Date arrived in U.S. ____/____/____ (month/year)</p>	<p>Reported by: _____</p> <p>Agency: _____</p> <p>Hospital# _____ DOC# _____</p> <p>Attending Physician: _____</p> <p>Address: _____</p> <p>Phone ____ (____) _____</p>
<p>11. Risk factors for exposure (check all that apply) Recent contact to TB case <input type="checkbox"/> Name of case _____ Born or spent time in a high-prevalence country <input type="checkbox"/>; Resident or employee of high-risk congregate settings (nursing homes, prisons, etc.) <input type="checkbox"/>; Health-care workers in high-risk settings <input type="checkbox"/>; Injection drug use <input type="checkbox"/>; Member of locally defined medically underserved, low-income groups <input type="checkbox"/>; Member of high-risk racial or ethnic minority groups <input type="checkbox"/>; Child exposed to adults in high-risk categories <input type="checkbox"/></p> <p>12. Risk factors for progression to disease Chest x-ray suggestive of previous TB and history of inadequate treatment <input type="checkbox"/> HIV-positive <input type="checkbox"/>; Substance abuse <input type="checkbox"/>; Recent infection (in last 2 years) <input type="checkbox"/> Prolonged corticosteroid or other immunosuppressive therapy <input type="checkbox"/>; Certain Medical Conditions: Diabetes mellitus <input type="checkbox"/>; Silicosis <input type="checkbox"/>; Head and neck cancer <input type="checkbox"/> Hematologic and reticuloendothelial disease (e.g., leukemia, Hodgkin's Disease) <input type="checkbox"/> End-stage renal disease <input type="checkbox"/>; Intestinal bypass or gastrectomy <input type="checkbox"/>; Chronic malabsorption syndromes <input type="checkbox"/>; 10% or more below ideal body weight <input type="checkbox"/></p>	<p>13. Skin test & TB disease history (record only PPD Mantoux test) Date given _____ Date read _____ Results _____ mm</p> <p>Previous diagnosis of TB? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, year of previous diagnosis _____</p> <p>14. HIV status Was HIV test offered? Yes <input type="checkbox"/> No <input type="checkbox"/> Offered & refused <input type="checkbox"/> Results: Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> If positive, based on: medical documentation <input type="checkbox"/> patient history <input type="checkbox"/></p> <p>15. Alcohol & drug use: History of excess alcohol intake? Yes <input type="checkbox"/> No <input type="checkbox"/> Within the past year? Yes <input type="checkbox"/> No <input type="checkbox"/> History of injecting drug use? Yes <input type="checkbox"/> No <input type="checkbox"/> Within the past year? Yes <input type="checkbox"/> No <input type="checkbox"/> History of non-injecting drug use? Yes <input type="checkbox"/> No <input type="checkbox"/> Within the past year? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>16. Has the patient been homeless within the past year? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="text-align: center;"><i>(Continued on the back)</i></p>

17. Resident of long-term care facility at time of diagnosis? Yes No Facility type _____

18. Resident of correctional facility at time of diagnosis? Yes No Facility type _____

19. Clinical symptoms: Productive, prolonged cough ; Hemoptysis ; Chest pain ; Night sweats ; Fever ; Chills
Weight loss ; Loss of appetite ; Fatigue ; Other _____

20. Chest x-ray: Normal ; Abnormal ; Not done Date of x-ray: _____ Previous Chest x-ray date (if known) _____

If abnormal: Cavitory ; Non-cavitory, consistent with TB ; non-cavitory, not consistent with TB

If abnormal: Stable ; Worsening ; Improving ; Unknown

21. Laboratory specimens: Sputum (dates collected) _____ AFB smear results: positive ; negative ; not done
Culture results (if available): MTB Negative Other

Other specimen (specify) _____ (date collected) _____ AFB smear results: positive ; negative ; not done
Culture results (if available): MTB Negative Other

DNA probe or other rapid test, if performed: MTB Negative Other mycobacteria

Laboratory performing the testing _____

22. Disease site: Pulmonary ; Pleural ; Lymphatic ; Bone & Joint ; Meningeal ; Laryngeal ; Miliary ; Other (specify) _____

23. Initial drug regimen: Isoniazid Rifampin Pyrazinamide Ethambutol Other (specify) _____ Vitamin B₆
Dose _____ Dose _____ Dose _____ Dose _____ Dose _____ Dose _____

24. Date therapy started _____ 25. Requesting drugs through ISDH: Yes (submit prescription & drug request form) No

Reminders

- Use of four drugs in the initial treatment regimen is highly recommended.
- There is a higher risk of drug resistance if the patient is from a country with a high prevalence of drug-resistance, has been inadequately treated for TB disease before, or has been a contact to someone with drug-resistant TB.
- Reevaluate if cultures are still positive or symptoms don't improve after 3 months of therapy.
- Initial specimens must have smear, culture, and drug susceptibilities ordered.
- Length of treatment is dependent upon culture conversion time.
- Adult patients with pulmonary or laryngeal TB are considered not infectious when they are on adequate therapy, their symptoms are improving, and there are 3 consecutive negative sputum smears that have been collected 24 hours apart.
- Directly Observed Therapy (DOT) is the standard of care in Indiana.