Tuberculosis Control Program

EpiTrax Tuberculosis Disease Form

Please print clearly

Investigator Name: _____ **Epitrax Case Number: _____**

Date of Investigation: _____

DEMOGRAPHIC TAB

Patient Name:_____ **Parent/Guardian_____**
Last, First, Middle

Address: _____
Street, City, Zip Code, County

Date of Birth: _____ **Birth Gender: _____** **Primary Language: _____**

Phone Number: _____

Please circle:

Ethnicity: Hispanic Non-Hispanic

Race: White Black/African-American American Indian/Alaskan Native Asian Hawaiian/Pacific Islander

Country of Birth:_____ **Date of Entry: _____**

Immigration Status (initial entry): Refugee Student VISA Tourist VISA Family Finances VISA
Employment VISA Immigrant VISA Other: _____

Patient lived outside the US for an uninterrupted period of > 2 years Y N

Parents of children under 15 years-of-age only:
Country of Birth: _____ (Birth Parent 1) **Country of Birth: _____ (Birth Parent 2)**

Emergency Contact Name: _____
Emergency Contact Relationship:_____
Emergency Contact Phone Number: _____ ie. (***)*-****

Does Patient have health insurance? Y N Company _____

CLINICAL TAB

Disease: (circle one) Active TB Suspect Infection (LTBI)
If Active TB is confirmed: Pulmonary or Extra-pulmonary (location)_____
Does Patient have TB symptoms? **Y N**

Please circle and date each symptom present:

Cough _____
Unexplained Weight Loss _____
Normal weight: _____
Current Weight: _____
Hemoptysis_____
Fever _____
Fatigue _____
Appetite Loss _____
Shortness of Breath _____
Night Sweats _____
Chest Pain _____
Other Symptoms (please specify):

Hospitalized: Y N Health Facility: _____
Admission Date: _____ Discharge Date: _____

CLINICAL TAB Cont.

Is the Patient Deceased? Y N Date of Death_____
Is the Patient Pregnant? Y N Expected Due Date: _____
Is the patient going to take TB treatment? Y N U/K
List TB Medications dosage and start dates on separate page
Clinician's Name:_____
Diagnostic Facility: _____

Medical History:

Previous TB tx? Y N date? _____
Pt. currently taking any meds? Y N
List medications on separate sheet
Medication Allergies? Y N
If yes, please list: _____
Diabetic? Y N circle one: Type 1 Type 2
Chronic Illnesses/Immune Problems? Y N
Please list chronic conditions on separate sheet

Received BCG vaccine? Y N
History of Hepatitis? Y N
A B C &/or Other
Date if HIV Test: _____
HIV Test results: _____

EPIDEMIOLOGICAL TAB

Risk Factors:

Reasons for current TST/IGRA? _____
If yes, document further information on a separate sheet:

History of smoking tobacco: Y N
History of IV drug use: Y N
History of Homelessness Y N
History of Extensive Travel Outside US Y N
List countries _____
History of non IV drug use: Y N
History of excessive alcohol use: Y N
Patient ever been in jail or prison: Y N
Patient ever lived in long term care facility Y N
Is patient a migrant/seasonal worker Y N

Has patient worked, volunteered in, or been a resident in: Healthcare Corrections Shelters
Describe type of facility patient worked, volunteered or lived: _____
Does the patient go to school? Y N Where? _____
Occupation during the last 12 months_____
Has the patient ever been a contact to someone with TB Disease? Y N _____

INVESTIGATION TAB

TST/IGRA, CXR/other Radiography – scan and attach reports. (Document scanning in Encounters.)

Previous TST: Y N U/K Date Read: _____ Millimeters of induration _____
Previous IGRA : Y N U/K Date: _____ QFT or T-Spot
Current TST: Y N U/K Date Read: _____ Millimeters of induration _____
Current IGRA: Y N U/K Date: _____ QFT or T-Spot

Previous Chest- Xray: Y N U/K When? _____ Results? _____
Current Chest- Xray: Y N U/K When? _____ Results? _____

CT Scan: Y N U/K When? _____ Results? _____

ADDL. INFO

Primary reason patient first evaluated for TB Disease? _____
_____

NOTES

Please scan and attached all supporting documents to EpiTrax: Hospital/Clinic Documents, Lab Work, etc.