Fax or mail to:
Connecticut Department of Public Health
Tuberculosis Control Program
410 Capitol Avenue, MS #11TUB
P.O. Box 340308
Hartford, CT 06134-0308
Phone: 860-509-7722 Fax: 860-509-7743

Tuberculosis Treatment and Follow-up Care Report Form

Complete for ALL TB Disease and Latent TB Infection

Patient Name – Last, First, Middle	Date of Birth (MM/DD/YYYY)	Date of This Evaluation (MM/DD/YYYY)
Address – Street, City, State, Zip	Best Phone Number	Date of Next Evaluation (MM/DD/YYYY)

This Patient is Being Treated For (please check one)

☐ Active TB Disease ☐ Latent TB Infection

Patient's Insurance Status – (if changed/new)

☐ Uninsured ☐ Medicare ☐ Medicaid ☐ Private ☐ Other (specify): _____

CURRENT TREATMENT

Start Date (MM/DD/YYYY)

Check Drug(s) / Complete Dosages for Current Treatment

☐ Isoniazid _____(mg) ☐ Rifapentine _____(mg)

☐ Rifampin _____(mg) ☐ Rifabutin _____(mg)

☐ Pyrazinamide _____(mg) ☐ Pyridoxine (B6) _____(mg)

End Date: _____ ☐ Other: _____(mg)

☐ Ethambutol _____(mg) ☐ Other: _____(mg)

End Date: _____ ☐ Other: _____(mg)

If one or more drugs were stopped, please indicate which drug(s) and date:

Directly Observed Therapy (DOT)

Is/Was Patient on DOT?

☐ Yes, totally DOT, if yes was it:
- ☐ In Person DOT
- ☐ Electronic DOT

☐ Yes, both DOT and self-administered

☐ No, totally self-administered

If yes, number of doses to date: _____

Treatment Status

☐ Continuing

☐ Completed — Date Completed (MM/DD/YYYY)

Total Months of Treatment: _____

☐ Treatment Stopped (Complete Date Stopped at right and check reason below) — Date Treatment Stopped (MM/DD/YYYY)

Provide reason treatment was stopped.

☐ Refused
☐ Not TB
☐ Adverse Treatment Event
☐ Lost
☐ Other: _____

☐ Died (complete date at right) — Date of Death (MM/DD/YYYY)

☐ Restarted (complete date at right) — If Restarted, Date (MM/DD/YYYY)

☐ Moved (enter new address below)

New Address:

Email address: _____

If moved, were records sent to new provider/health department? ☐ Yes ☐ No

NEW TESTING AND FOLLOW-UP, ATTACH COPIES OF ALL NEW RESULTS

HIV

All TB patients should have testing. If HIV testing was pending, or not initially offered, what are the results now?

☐ Positive ☐ Pending
☐ Negative ☐ Refused
☐ Indeterminate

Date Tested (MM/DD/YYYY)

HEPATITIS

Was patient tested for hepatitis? ☐ No ☐ B ☐ C

If YES, was patient positive for: ☐ B ☐ C

Date Tested (MM/DD/YYYY)

COMPARATIVE IMAGING

Recommended **TWO** months after treatment started for TB disease. ☐ CXR ☐ CT Scan ☐ Other: _____

Results: ☐ Stable ☐ Improving ☐ Worsening

Date Tested (MM/DD/YYYY)

BACTERIOLOGY

Date first consistently negative sputum culture. (MM/DD/YYYY)

If no sputum culture conversion within 60 days (select one):

☐ Still positive culture
☐ NO follow-up sputum despite induction
☐ NO follow-up sputum and NO induction
☐ Patient Lost
☐ Patient Refused
☐ Died
☐ Other (specify): _____

ADDITIONAL INFORMATION

Comments:

PROVIDER INFORMATION

Current Health Care Provider: (Name and Address)

Telephone: ( )

Fax: ( )

Name of Person Completing This Report

Telephone: ( )

Date of This Report (MM/DD/YYYY)

MAIL: White copy to CT Department of Public Health, Yellow copy to the Local Health Department, and Pink to the patient's file.