TUBERCULOSIS CLINIC RECORD

SNOHOMISH HEALTH DISTRICT

Last, First, MI _____

Street _____

City, State, Zip _____

DOB: / / Age: _____ ___M ___F

SS# _____

Telephone Home: _____

Message: _____

Insurance PIC#

OCCUPATION	
	Unemployed
	1st Response
	HCW (pt. contact)
	Corrections
	Other:
EMPLOYER:	

DATE OF VISIT

/ /

Y	N	MEDICAL HISTORY
		Height _____ in
		Weight _____ lb
		≥10% Below Ideal Body Weight
		Diabetes _____ Insulin _____ Oral
		Renal Failure
		Silicosis
		Cancer _____ Heme _____ Lymph _____ Other
		Current Cancer Chemotherapy
		HIV Infection
		Other Immunosupression
		HX Major GI Surgery /Bowel Resection
		Chronic Peptic Ulcer Disease
		IDU Ever Last Injected
		Long Term Care Facility Resident
		Incarcerated Currently or in the Past
		Other
		RISK FACTORS FOR LIVER TOXICITY
		Chronic Liver Disease
		Hx Hepatitis: B C Other Date
		Alcohol: ≥10 Drinks Per Week
		Other:
		CURRENT MEDS: Agent, Dose & Freq
		Steroids:
		Antiseizure Meds:
		Anticoagulants
		Methadone:
		Other Medications:

ALLERGIES	
	None

PMD:

PMD Phone #

MARITAL STATUS: S M D W Sep.

RACE / ETHNICITY	
	White
	Black
	Hispanic
	Asian/PI
	Native AM / AK Native
	Speaks English ____ Yes ____ No

REASON FOR REFERRAL	
	Symptoms of TB
	Refugee/Immigration Exam
	Source Case Finding
	Recent Contact (name):
	TB Suspect Referral
	Referred by PMD
	Occup. Screen
	Drug Rx Prog.
	Jail Referral
	Other (specify)

TOBACCO USE	
	Never
	Former: ____ Pack Years Quit____Yrs. Ago
	Current: ____ Pack Years
	Counseling/ Referral Given

NATION OF ORIGIN	
Alien #	
DATE OF IMMIG	
	Month
	Year
DURATION IN WA STATE	
	Years

OTHER STATES/ COUNTRIES LIVED IN FOR > 6 MONTHS (Check Most Recent)	

Y	N	TB HISTORY
		Active TB
		Previous PPD+
		Anti-TB Meds
		Expo Active TB When?
		Other:

HISTORY OF BCG:

❒ Yes ❒ No

If yes, # years since last dose _____

SYMPTOMS		WK
	None	
	Cough	
	Sputum	
	Hemoptysis	
	Lymphadenopathy	
	Hoarseness	
	Chest Pain	
	Dyspnea	
	Fever	
	Night Sweats	
	Wt Loss: lb	
	Fatigue	
	Anorexia	
	Other:	

HIV C & T

Most Recent Test -

Date:_____

Results:_____

Declined to Test:_____

HIV RISK ASSES.		
Y	N	RISK
		IDU (ever)
		Ptnr IDU
		MSM
		Prtnr MSM
		Prtnr HIV+
		Sex for $/Drugs
		Child born to HIV +

Y	N	REPRODUCTIVE HEALTH
		LMP Date _____
		Contraception Method:
		Pregnant: Trimester 1 2 3 No
		PP (weeks) _____

REFUGEE EXAM	
HGB	
BP	
Other	

Sputum Collection: ___Yes ___No

Date: _____ _____ _____

CXR appointment: _____ _____

date time

❒ Recommend client for DOPT

❒ Recommend client for self administered

COMMENTS

PREVIOUS PPD HISTORY (If Available)

TEST	DATE APPLIED	DATE READ	MM	Where Done
Next Previous				
Previous				
Most Recent				

SHD PPD RECORD

Date/Time Applied	Date/Time Read	MM	MR	PR

Targeted Testing: Project Individual Administrative

STAFF SIGNATURE DATE

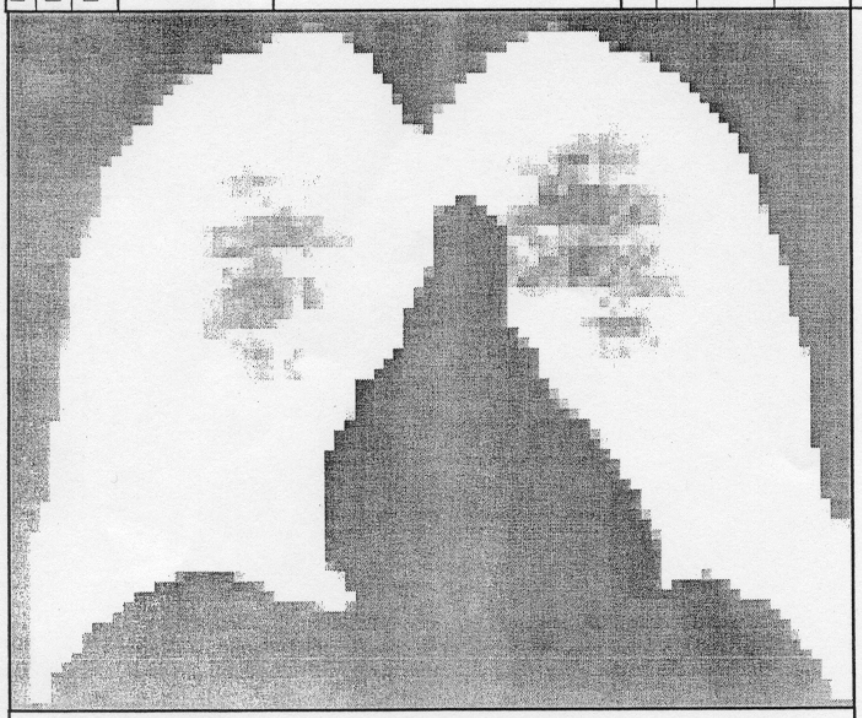
TUBERCULOSIS CLINIC RECORD
SNOHOMISH HEALTH DISTRICT

Client Name _____ Birth Date _____

MD SECTION

X-RAY

View			Date Taken	Where Taken	Results				If Abnormal			Status			
P/A	Lat	Other			NI	Abn	Not Done	Unknown	Cavitary	Non-Cavitary Consistent w/TB?		Stable	Worsening	Improving	Unknown
☐	☐	☐			☐	☐	☐	☐		☐ consistent	☐ not consist.	☐	☐	☐	☐
P/A	Lat	Other			NI	Abn	Not Done	Unknown	Cavitary	Non-Cavitary Consistent w/TB?		Stable	Worsening	Improving	Unknown
☐	☐	☐			☐	☐	☐	☐		☐ consistent	☐ not consist.	☐	☐	☐	☐
P/A	Lat	Other			NI	Abn	Not Done	Unknown	Cavitary	Non-Cavitary Consistent w/TB?		Stable	Worsening	Improving	Unknown
☐	☐	☐			☐	☐	☐	☐		☐ consistent	☐ not consist.	☐	☐	☐	☐



WORKING DIAGNOSIS / CLASSIFICATION

	0: Not Exposed, Not Infected
	1: Exposed, Not Infected
	2: Latent TB Infection
	3: Tuberculosis — Active Disease
	4: Tuberculosis — Old, Inactive
	5: Suspect
	Other:

Y | N | ADDITIONAL ORDERS

- ☐ Sputum x 3 for AFB
- ☐ F/U CXR:
  ___Cultures Final __End Therapy
  Other_____
- ☐ Isolate
- ☐ X-ray, Lordotic View
- ☐ Routine Medication Education
- ☐ Monthly Clinical Evaluation
- ☐ Hepatic Profile Baseline & Monthly
- ☐ CMP/CBC baseline & monthly
- ☐ F/U PPD 12 weeks after last exposure
- ☐ MD Office Visit
- ☐ MD or Nurse Exam at Rx start
- ☐ Refer to primary care for_____
- ☐ Other_____
  _____

INITIAL TREATMENT ORDERS

- ☐ None
- ☐ INH per protocol X 9 months
- ☐ B6 per protocol X 9 months
- ☐ _____
- ☐ Supervision: ___DOT ___Nurse Discretion
- ☐ Other

SITES INVOLVED

- ☐ Not Applicable
- ☐ Pulmonary only
- ☐ Extra pulmonary only (site: _____)
- ☐ Pulmonary & Extra pulm. (site: _____)

SHD MD COMMENTS

SHD MD SIGNATURE _____ DATE _____

DJV

SHD-37 Rev. 9/2005