DIRECT OBSERVATION THERAPY REFERRAL

Daily / Weekly DOT (circle one) Patient Name:____

Male/Female (circle one) Age:__________AKA:____

Address:____

Phone Number (Home/Message):____________________ Phone Number (Work):________________________

Work Name & Address: ____

DOB:______________ Social Security #:_____-_____-_____ Medi-Cal ID#: ___________________________

CLINICAL FINDINGS

Date of Symptom Onset:_____/_____/_____ Date of Diagnosis:_____/_____/_____ Weight:_______lbs.

Site: Pulmonary/Laryngeal/Extrapulmonary(Specify)____

Prior TB Drug Treatment: Yes/No/Unknown If Yes, any prior drug resistance? Yes/No/Unknown

Prior Drug Therapy Compliance? Yes/No/Unknown

Initial Symptoms: Cough/Sputum Production/Other____

Date Last Chest X-Ray: _____/_____/_____ Result: Normal/Abnormal (noncavity)/Abnormal (cavity)

If Abnormal: Stable/Worsening/Improving/No Prior Films

Most Recent PPD: ____/____/____ Reaction:_____mm Last Prior PPD:____/____/____ Reaction:_____mm

BACTERIOLOGY UPDATE:

Date	Source	AFB Smear Results	AFB Culture Results	Laboratory

CURRENT MEDICATION REGIME:

Medication	Dosage/ Frequency	Date Started	Anticipated Treatment Length	Number of Doses	
				Prescribed	Dispensed
INH					
RIF					
PZA					
EMB					

REASON FOR REFERRAL/NOTES:____

____

____

Next Appointment Date:_____/_____/_____ Physician Name/Phone #:___________________________________

Person Completing Form:____________________________________ Fax Number:______________________

Today's Date: _____/_____/_____

ORIGINAL TO LOCAL TB CONTROL OFFICER

COPY TO HEALTH NET'S PUBLIC HEALTH COORDINATOR