TUBERCULOSIS SUSPECT CASE REPORT

Patient_____
Address_____
_____
Phone ( )_____

Reported by_____
_____
_____
Phone ( )_____

DOB:_____/_____/_____ Sex: M☐ F☐

Social Security Number_____-_____-_____
Employer/School_____
If under 18, list parent name and DOB:
_____

Hospital/Clinic of Dx_____
Medical Record Number_____
Treating Physician_____
Phone_____
Consulting Physician_____
Phone_____

Skin Test (PPD) Date_____/_____/_____ Reading___mm X___mm Anergic Y___ N___ Unk___

Chest X-ray Date_____/_____/_____ Impresssion_____
_____

Pulmonary TB_____ Extra Pul. TB_____ Site_____ Date of Diagnosis____/_____/____

If Pul TB, check symptons: cough_____ sputum production_____ hemoptysis_____
night sweats_____ wt. loss_____(lbs)

Past history of TB treatment Y_____ N_____ If yes, where & when_____

Other medical conditions relevant to diagnosis_____

BACTERIOLOGY

Specimen Number	Specimen Date	Specimen Type	Smear AFB - or +	Culture M. Tb - or +

Lab Name:
Account Number:

MEDICATION

Medication	Dose	Start Date

Allergies:

HIV Status_____Psychosocial History_____
_____

Additional Comments_____
_____

Date Reported _____/_____/_____ Recorded by _____