TUBERCULOSIS SUSPECT CASE REPORT
Tulare County Department of Health Services

Within 24 hours of diagnosis or suspicion of TB, complete Part I and II and FAX to TCDHS TB Division – FAX: (559) 685-4786

PART I: PATIENT/FACILITY INFORMATION

Date: ___/___/___

Name: _____ **Alias:** _____
LAST FIRST MI LAST FIRST MI

Address prior to admission: _____
STREET CITY ZIP CODE COUNTY

Sex: _____ **Age:** _____ **DOB:** _____ **Phone: ( )** _____

Race/Ethnicity:
___ White, non-Hispanic
___ Black, non-Hispanic
___ Hispanic
___ Native American/Alaskan American
___ Asian/Pacific Islander (specify) _____
___ Other (specify) _____

Name and Address of Workplace: _____

Social Security #: _____

Primary Language if other than English: _____

Medical Record #: _____

Chemically dependent? ☐ Yes (specify drug): _____ ☐ No **Homeless?** ☐ Yes ☐ No
AIDS? ☐ Yes ☐ No (HIV + TB = AIDS)

History of medical noncompliance? ☐ Yes ☐ No ☐ Unk **DOT Anticipated?** ☐ Yes ☐ No ☐ Unk
Person to notify in case of emergency: NAME: _____ **PHONE:** ( )
Legal guardian or contact person (if applicable): NAME: _____ **PHONE:** ( )
FACILITY NAME: _____ **Admission Date:** ___/___/___
Attending Physician: _____ **PHONE:** ( )

PART II: CLINICAL FINDINGS

Date of Symptom Onset: ___/___/___ **Date of Diagnosis:** ___/___/___ **Weight:** _____ **lbs.**

Site: ☐ Pulmonary ☐ Laryngeal ☐ Extrapulmonary (specify) _____
Prior TB drug treatment? ☐ Yes ☐ No ☐ Unknown **INITIAL SYMPTOMS:**
If yes, prior TB drug resistance? ☐ Yes ☐ No ☐ Unknown **Cough sputum production?**
Prior TB drug adherence? ☐ Yes ☐ No ☐ Unknown ☐ Yes ☐ No ☐ Unknown
Last CXR: ___/___/___

Most recent PPD: ___/___/___ **Reaction:** _____ mm **Results:** ☐ Normal
Last prior PPD: ___/___/___ **Reaction:** _____ mm ☐ Abnormal (noncavitary)
Anergic test? ___/___/___ **Reaction:** _____ mm ☐ Abnormal(cavitary)

BACTERIOLOGY: **(Include all specimens collected during current admission)**

Date (Month/Day/Year)	Source	AFB Smear Results	AFB Culture Results	Laboratory

Initial Drug Regimen (circle drugs) **INH RIF PZA EMB Other (specify)** _____ **Date Started:** _____
Form Completed by: _____ **Phone:** _____