



**DEPARTMENT OF HEALTH
REPORT OF TUBERCULOSIS**

State Form 14058 (R6/9-03)

INDIANA STATE DEPARTMENT OF HEALTH
2 North Meridian Street, Section 6-A
Indianapolis, IN 46204
(317) 233-7434

TB Law: Every suspected and verified case of tuberculosis disease must be reported to the local health officer within 72 hours (from probable diagnosis) in accordance with 410 IAC 1-2.3

<p>1. Patient name (Last, First, MI): _____</p> <p>2. Address _____</p> <p>City _____ Within city limits: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Phone (____) _____</p> <p>County _____ Zip Code _____</p> <p>3. Date of birth ____ - ____ - ____ 4. At time of report: Alive <input type="checkbox"/> Dead <input type="checkbox"/></p> <p>5. Age _____ 6. Sex: Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p>7. Occupation _____</p> <p>Place of Employment/School _____</p>	<p style="text-align: center;">FOR LOCAL HEALTH DEPARTMENT USE ONLY</p> <p>Date received at local health department _____</p> <p>Received by _____</p> <p>Phone ____ (____) _____</p>
<p>8. Race: Check all that apply</p> <p>White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/></p> <p>Black or African-American <input type="checkbox"/> Hawaiian Native or other Pacific Islander <input type="checkbox"/></p> <p>9. Ethnic origin: Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/></p> <p>10. Born in the United States: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "No," what is the country of birth _____</p> <p>Date arrived in the U.S. ____ -- ____ (month/year)</p>	<p>Reported by: _____</p> <p>Agency: _____</p> <p>Phone (____) _____</p> <p>Attending Physician: _____</p> <p>Address: _____</p> <p>Phone ____ (____) _____</p>
<p>11. Risk factors for exposure (check all that apply)</p> <p>Recent contact to TB case <input type="checkbox"/> Name of case _____</p> <p>Birth in a country where TB is common <input type="checkbox"/></p> <p>Injection drug use <input type="checkbox"/></p> <p>HIV infection <input type="checkbox"/></p> <p>Substance abuse, including alcohol <input type="checkbox"/></p> <p>Other high-risk medical condition: _____</p> <p>Resident or employee of high-risk congregate setting <input type="checkbox"/></p> <p>Health care worker serving high-risk clients <input type="checkbox"/></p> <p>Member of locally defined medically underserved, low income group <input type="checkbox"/></p> <p>Member of high-risk racial or ethnic minority group <input type="checkbox"/></p> <p>Child exposed to adults in high-risk categories <input type="checkbox"/></p> <p>Other (explain): _____</p>	<p>13. Skin test & TB disease history (record only PPD Mantoux test)</p> <p>Date given _____ Date read _____ Results _____ mm</p> <p>Previous diagnosis of TB? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, year of previous diagnosis _____</p> <p>14. HIV status</p> <p>Was HIV test offered? Yes <input type="checkbox"/> No <input type="checkbox"/> Offered & refused <input type="checkbox"/></p> <p>Results: Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/></p> <p>If positive, based on: medical documentation <input type="checkbox"/> patient history <input type="checkbox"/></p> <p>15. Alcohol & drug use:</p> <p>History of excess alcohol intake? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>History of injecting drug use? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>History of non-injecting drug use? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>16. Has the patient been homeless within the past year? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="text-align: center;"><i>(Continued on the back)</i></p>

17. Resident of long-term care facility at time of diagnosis? Yes No Facility type _____

18. Resident of correctional facility at time of diagnosis? Yes No Facility type _____

19. Clinical symptoms: Prolonged productive cough Hemoptysis Chest pain Night sweats Fever Chills
Weight loss Loss of appetite Fatigue Other _____

20. Chest x-ray: Normal Abnormal Not done Date of x-ray: _____ Previous Chest x-ray date (if known) _____

If abnormal: Cavitory Miliary Non-cavitory, consistent with TB non-cavitory, not consistent with TB

If abnormal: Stable Worsening Improving Unknown

21. Laboratory specimens: Sputum only (dates collected) _____ AFB smear results: positive negative

Culture results (if available): *M. tuberculosis* complex Not identified Other

Specimens other than sputum (specify) _____ (date collected) _____ AFB smear results: positive negative

Culture results (if available): *M. tuberculosis* complex Not identified Other

Amplified Direct Test: Positive Negative Not Performed (this refers to nucleic acid amplification tests performed directly on the specimen, **not** DNA probes used to identify the culture)

Laboratory performing the testing _____

22. Disease site(s): Pulmonary Pleural Lymphatic Bone & Joint CNS Other (specify) _____

23. Initial drug regimen: Isoniazid Rifampin Pyrazinamide Ethambutol Other (specify) _____ Vitamin B₆
Dose _____ Dose _____ Dose _____ Dose _____ Dose _____ Dose _____

Patient weight: ____ Kg or ____ pounds

24. Date therapy started _____ 25. Requesting drugs through ISDH: Yes (submit prescription & drug request form) No

Reminders:

- Initial treatment regimen for adults and children old enough to have their visual acuity and color vision monitored (≥ 5 years of age) should include all 4 first-line drugs: isoniazid, rifampin, pyrazinamide, and ethambutol.
- There is a higher risk of drug resistance if the patient is (1) from a country with a high prevalence of drug-resistance, (2) has been treated for TB disease before, or (3) has been a contact to someone with drug-resistant TB.
- Directly Observed Therapy (DOT) is the standard of care in Indiana.

For Local Health Department use regarding foreign-born patients: Entered the U.S. on a class B-1 or B-2 waiver? Yes No Refugee Yes No

Alien Number, if not a U.S. citizen: _____