

REPORT OF PATIENT SERVICES

By law this form must be submitted
 for every monthly visit of patients
 with active tuberculosis.

Please print firmly and legibly

TB Registry Number	Social Security Number	Chart Number
Patient Name: _____		
Last	First	M.I.

Address	Apt. #	Zip Code

Daytime Phone () _____	Evening Phone () _____	Date of Birth _____ / _____ / _____ Month Day Year

If patient missed appointment, check here and go to box at bottom of page. (Date of missed appointment _____ / _____ / _____)
 Month Day Year

TB Site of Disease (check all that apply):

Pulmonary Other (Specify) _____

Pleural _____

Lymphatic _____

Meningeal _____

Latest chest X-ray: _____ / _____ / _____
 Month Day Year

Normal

Abnormal-noncavitary (including adenopathy)

Abnormal-cavitary

Findings: _____

If prior films available; is this film

Stable Worsening Improving

Most recent bacteriology:

Date specimen collected: _____ / _____ / _____
 Month Day Year

Source of Specimen: _____

Smear:	Culture:
<input type="checkbox"/> Positive	<input type="checkbox"/> Positive
<input type="checkbox"/> Negative	<input type="checkbox"/> Negative
<input type="checkbox"/> Pending	<input type="checkbox"/> Pending

If culture positive:
 M.tb Other _____

Was susceptibility ordered? Yes No

<p>Medications prescribed at this visit?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____</p> <p>Medication regimen changed this visit?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____</p> <p>Is patient on Directly Observed Therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____</p>	<p>Frequency of DOT:</p> <p><input type="checkbox"/> Daily</p> <p><input type="checkbox"/> 2x per week</p> <p><input type="checkbox"/> 3x per week</p> <p><input type="checkbox"/> 5x per week</p> <p><input type="checkbox"/> once a week</p>															
<p>Drugs and dosages:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> INH _____ mg</td> <td><input type="checkbox"/> RIF _____ mg</td> <td><input type="checkbox"/> PZA _____ mg</td> </tr> <tr> <td><input type="checkbox"/> EMB _____ mg</td> <td><input type="checkbox"/> SMN _____ mg</td> <td><input type="checkbox"/> PAS _____ mg</td> </tr> <tr> <td><input type="checkbox"/> Ethio _____ mg</td> <td><input type="checkbox"/> CYC _____ mg</td> <td><input type="checkbox"/> Kana/AMI _____ mg</td> </tr> <tr> <td><input type="checkbox"/> RPT _____ mg</td> <td><input type="checkbox"/> Levo _____ mg</td> <td><input type="checkbox"/> Capreo _____ mg</td> </tr> <tr> <td><input type="checkbox"/> RBT _____ mg</td> <td><input type="checkbox"/> Other _____</td> <td><input type="checkbox"/> MOXI _____ mg</td> </tr> </table>		<input type="checkbox"/> INH _____ mg	<input type="checkbox"/> RIF _____ mg	<input type="checkbox"/> PZA _____ mg	<input type="checkbox"/> EMB _____ mg	<input type="checkbox"/> SMN _____ mg	<input type="checkbox"/> PAS _____ mg	<input type="checkbox"/> Ethio _____ mg	<input type="checkbox"/> CYC _____ mg	<input type="checkbox"/> Kana/AMI _____ mg	<input type="checkbox"/> RPT _____ mg	<input type="checkbox"/> Levo _____ mg	<input type="checkbox"/> Capreo _____ mg	<input type="checkbox"/> RBT _____ mg	<input type="checkbox"/> Other _____	<input type="checkbox"/> MOXI _____ mg
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Services provided
 Check all that apply:

Doctor visit

Nurse visit

X-ray

Sputum sample

Audiometry

Liver enzymes

Vision testing

Other _____

Date of this visit: _____ / _____ / _____ Date of next visit: _____ / _____ / _____
 Month Day Year Month Day Year

Management Course/Outcome:

Completed treatment

Expired – was cause of death TB? Yes No

Moved/transferred (where): _____

Rehospitalized (where): _____

Other _____

M.D. Name: _____ M.D. License # _____

Facility: _____ Prepared by: _____ Phone: () _____