Bureau of Tuberculosis Control
42-09 28th Street, Box 72
Long Island City, N.Y. 11101
844-713-0559/ FAX: 844-713-0557

REPORT OF PATIENT SERVICES

Please print firmly and legibly

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

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
- ❑ Pleural
- ❑ Lymphatic
- ❑ Meningeal
- ❑ Other (Specify) _____

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:
❑ Positive	❑ Positive
❑ Negative	❑ Negative
❑ Pending	❑ Pending

If culture positive:
❑ M.tb ❑ Other _____
Was susceptibility ordered? ❑ Yes ❑ No

Medications prescribed at this visit?
❑ Yes ❑ No Reason: _____
Medication regimen changed this visit?
❑ Yes ❑ No Reason: _____
Is patient on Directly Observed Therapy?
❑ Yes ❑ No Reason: _____

Frequency of DOT:
- ❑ Daily
- ❑ 2x per week
- ❑ 3x per week
- ❑ 5x per week
- ❑ once a week

Drugs and dosages:

❑ INH ____ mg	❑ RIF ____ mg	❑ PZA ____ mg
❑ EMB ____ mg	❑ SMN ____ mg	❑ PAS ____ mg
❑ Ethio ____ mg	❑ CYC ____ mg	❑ Kana/AMI ____ mg
❑ RPT ____ mg	❑ Levo ____ mg	❑ Capreo ____ mg
❑ RBT ____ mg	❑ Other ____	❑ MOXI ____ mg

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: ( ) ___

COPIES: White–DOHMH; Yellow–Chart; Pink–Clinic Records