Confidential TB Suspect/Disease Report

Spokane County • Tuberculosis Control Program
TEL (509) 324-1613 FAX (509) 327-0163

SPOKANE REGIONAL HEALTH DISTRICT

Patient: _____
First MI Last
Address: _____
_____
Phone: _____
Date of Birth: _____
Sex: ☐ Male ☐ Female
Preferred Language: _____
Employer/School: _____
Occupation: _____
Race: ☐ White ☐ Black ☐ American Indian
☐ Alaska Native ☐Asian (Specify) _____
☐ Pacific Islander (Specify) _____
Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Country of Birth: _____
Date of Entry into the U.S.: _____

Reported by: _____
Report date: ___/___/___
Phone: _____ **Fax:** _____

Pt. currently hospitalized? ☐ Yes ☐ No Adm. Date: ___/___/___
Treating Physician: _____
Name of Hospital/Clinic: _____
Address: _____
_____
Phone: _____

If patient is under 18, legal guardians full name and phone #:
_____

Date of Diagnosis: ___/___/___

☐ Pulmonary TB ☐ Extra Pulmonary TB
Site: _____

If Pulmonary, check symptoms:
☐Cough ☐Night Sweats ☐Hemoptysis
☐Sputum Production ☐Weight loss _____ (lbs.)
Date of Onset: ___/___/___
If asymptomatic, reason for evaluation: _____
_____
_____

Skin Test Date: ___/___/___
Result: _____ mm
☐ Not Done
☐ Unknown

IGRA Test Date: ___/___/___
☐ QuantiFERON ☐ T-Spot
☐ Positive ☐ Negative
☐ Indeterminate

Chest X-Ray Date: ___/___/___ ☐Cavitary ☐Non-Cavitary
Impression: _____
_____
_____

Bacteriology ☐ **Not done**

Specimen Collection Date	Specimen Type	AFB Smear +/-	Culture M. tb +/-

Lab Name: _____
Allergies: _____

HIV Status: ☐ Positive ☐ Negative ☐ Unknown
☐ Not done ☐ Refused ☐ Pending
Date: ___/___/___

Treatment ☐ **Not Started**

Medication	Dose	Start Date
Isoniazad		
Rifampin		
Ethambutol		
Pyrazinamide		
Rifamate		
Rifabutin		

_____
Patient Weight: _____ (lbs.)
Date: ___/___/___

PLEASE ATTACH COPIES OF ALL LAB AND RADIOLOGY REPORTS

updated: 03/14/2017 KD