Iowa Department of Public Health - TB Control Program
TB Suspect/Active Patient Intake Form

Name (Last/First):_____ **Date:** _____

Address: _____ **City:**_____ **Zip:**_____ **County:**_____

Phone(Home):_____ **Phone(Cell):**_____

D.O.B: _____/_____/_____ **SEX: ☐ Male ☐ Female** **Weight:**_____

Race: ☐ *White* ☐ *Black/A.A.* ☐ *Asian* ☐ *Am. Indian/Alaskan* ☐ *Native Hawaiian/Pacific Islander* Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employer/Occupation: _____ **Health Insurance:** ☐ Yes ☐ No

Following HCP: _____ **Nurse:** _____ **Phone:** _____ **Fax:** _____

LPHA Contact	
Testing and Site of Disease:	TST Date_____ ☐ Pos ☐ Neg ☐ Not Done IGRA Date_____ ☐ Pos ☐ Neg ☐ Indeterminate ☐ Not Done ☐ Pulmonary ☐ Extrapulmonary (specify)_____ Previous Diagnosis of TB Disease? ☐ No ☐ Yes Year:_____
Isolation Orders	Isolation order issued: ☐ No ☐ Yes Date:_____ Date released from Isolation: _____
Chest X-Ray CT Scan	Initial CXR Date:_____ ☐ Normal ☐ Abnormal ☐ Not Done Evidence of cavity? ☐ Yes ☐ No Evidence of miliary TB? ☐ Yes ☐ No CT Scan Date:_____ ☐ Normal ☐ Abnormal ☐ Not Done Evidence of cavity? ☐ Yes ☐ No Evidence of miliary TB? ☐ Yes ☐ No
Symptoms	☐ Cough, Onset date: _____ ☐Chest pain ☐Hemoptysis ☐Fever/Chills ☐Night sweats ☐Weight loss ☐Fatigue
Primary Reason for TB Evaluation	☐TB Symptoms ☐Abnormal CXR ☐Contact Investigation ☐HCW ☐Immigrant Medical Exam ☐Incidental Lab
Risk Factors	☐ Foreign Born Country of Origin:_____ Month/Year Arrived in US_____ ☐Close contact of case ☐HCW's ☐Non-IDU ☐IDU ☐Alcohol ☐ Resident LTCF or CF ☐Missed Contact ☐Incomplete LTBI TX ☐Medical Risk Factors ☐Homeless
HIV Status (Req. for 18 – 50yo)	Date(s) Requested/To whom:_____ Results: ☐ Positive ☐ Negative ☐ Not Offered ☐ Refused
Sputum's/Other Specimen*	Sputum: ☐ Neg ☐ Pos ☐ Not Applicable Sputum Collection Date(s)/Results:_____ MTD: ☐ Neg ☐ Pos Result date:_____ AccuProbe: ☐ Neg ☐ Pos Result date:_____ **For Sputum Culture-Positive TB patients:** documented conversion to sputum culture-negative within 60 days of initiating treatment? ☐ Yes Date:_____ ☐ No
TB Contacts	Case For Contact Investigation? ☐ Yes ☐ No Children under 5? ☐ Yes ☐ No 1st Round Results Reported ☐ Yes ☐ No 2nd Round Results Reported ☐ Yes ☐ No IDSS Data Entry: ☐ LHD ☐TB Program
TB MEDICATIONS **Start Date**_____ **End Date**_____	☐ INH ☐ RIF ☐ EMB ☐ PZA 2nd Line Drugs ☐Yes ☐No Counseled – EMB/Vision Tests? ☐ Yes Date:_____ Reason TX Stopped: ☐ Completed ☐ Other (specify):_____ DOT: ☐ Yes ☐ No DOT: ☐ 100% ☐ Self Admin ☐ Combination Number weeks DOT:_____
Immigration Status at 1st Entry to the U.S.	☐ Immigrant Visa ☐ Student Visa ☐ Employment Visa ☐ Tourist Visa ☐ Family/Fiancé Visa ☐ Refugee ☐ Asylee or Parolee ☐ Other Immigrant Status ☐ Unknown ☐ Not Applicable

*Non-Infectious Criteria: 1) effective treatment for ≥2 weeks; 2) diminished symptoms; and 3) mycobacteriologic response (e.g., decrease in grade of sputum smear positivity detected on sputum-smear microscopy).

Rev: 3-11

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Case Notes