Maryland Case/Cohort Review Form

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| Conference Date: | | | | | | | | County: | | | | | | | | | | Prescribing Physician: | | | | | | | | | | State Case #: | | | | | | |
| 1. **CASE DESCRIPTION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Name: | | | | | Last Name: | | | | | | | | Sex: | DOB: | | | Country of Origin: | | | | | | Race/Ethnicity: | | | Year of US Arrival: | | | | | Class: | | | |
| Ht: | | | | | | Wt: | | | | | | | | Has there been a previous consult for this patient: | | | | | | | | | | | | | | | | | | | | |
| Date Reported to LHD: | | | | | |  | | | | | | | | Related Hospitalization: | | | | | | | | | | | | | | | | | | | | |
| Date Interviewed by LHD: | | | | | |  | | | | | | | |
| Date of Symptom Onset: | | | | | |  | | | | | | | |
| Other Health Problems: | | | | | | | | | | | | | | Nurse Assessment/Concerns: | | | | | | | | | | | | | | | | | | | | |
| Risk Factors | | | | | | | | | | | | | | Symptoms | | | | | | | | | | | History | | | | | | | | | |
|  | None | | |  | | Heavy Alcohol Use | | | | | | | |  | Cough | | | | |  | Hemoptysis | | | | LTBI History | |  | | | Yes | |  | No | Year: |
|  | IVDA | | |  | | Homeless | | | | | | | |  | Night Sweats | | | | |  | Weight Loss | | | | Completed Tx | |  | | | Yes | |  | No |
|  | Non-IVDA | | |  | | Contact | | | | | | | |  | Chest pain | | | | |  | Fever | | | | TB History | |  | | | Yes | |  | No | Year: |
|  | Congregate Care Resident | | |  | | TNF-α or Other  Immunomodulatory Drugs | | | | | | | |  | Enlarged Lymph Node | | | | |  | Other | | | | Completed Tx | |  | | | Yes | |  | No |
|  | Other | | | | | | | | | | | | | Notes: | | | | | | | | | | | | | | | | | | | | |
|  | Diabetes A1C: | | | | | | | | | | | | |
| HIV:       CD4:      On ART: | | | | | | | | | | | | | |
| 1. **TESTING** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TST in mm:      Date: | | | | | | | | | | | | | | | | | | | IGRA:       Date: | | | | | | | | | | | | | | | |
| Chest X-ray Date:       Result:       Notes:  Chest CT Date:       Result:       Notes:  Other Imaging Date:       Result:       Notes: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Test | | | Specimen Site | | | | | | | Date Collected | | | | | | Result | | | | | | Rifampin Susceptible | | | | | | | Notes | | | | | |
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| Culture Conversion:       Conversion within 60 days from treatment start:  Pan Sensitive on Phenotypic/Conventional Testing:       If No, Resistance to:  Resistance Detected on Genotypic/Molecular Testing:       If Yes, Resistance to:  Therapeutic Drug Monitoring:       Date Collected:       If Yes, Result: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **TREATMENT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Intensive Phase | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medication | | | | | | | Dosage | | | | | Frequency | | | | | | Start Date | | | | | | Stop Date | | | | | Number DOT Doses | | | | | |
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| Continuation Phase | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medication | | | | | | | Dosage | | | | | Frequency | | | | | | Start Date | | | | | | Stop Date | | | | | Number DOT Doses | | | | | |
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| Completed Therapy:       Currently Taking TB Meds:       Weeks of Treatment Completed:      Likely to Complete By: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If Not Completed, Reason Therapy Stopped:  Lost  Died  Refused  Adverse Reaction Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **CONTACT INVESTIGATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| High/Medium Risk Contacts | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Infectious Period Start Date:       Infectious Period End Date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Household Number:      Number of Children <5 years old:      Source Case Investigation Initiated: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Worksite Name:      # of persons:      School Name:      # of persons: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | Identified | | | | | | |  | | Total LTBI | | | | | | | Notes: | | | | | | | | | | | | | | | | |
|  | | 1st Round Testing | | | | | | |  | | # Converters | | | | | | |
|  | | 2nd Round Testing | | | | | | |  | | Started TLTBI | | | | | | |
|  | | Window Treatment | | | | | | |  | | Completed TLTBI | | | | | | |
|  | | Completed Evaluation | | | | | | |  | | TB Disease | | | | | | |

#### Question: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Recommendation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MD SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_