

Interjurisdictional Tuberculosis Notification

Referring Jurisdiction city _____ county _____ state _____ Date sent / /
 Contact person _____ Phone () _____ FAX () _____

Verified case → State where reported: _____ RVCT# _____ (attach RVCT) Not reported _____
 Suspect case Close contact Reactor LTBI Convertor Source case investigation

Patient name _____ Sex Male Female
Last First Middle
 Date of birth / / Interpreter needed? No Yes, specify language _____
 New address _____ Hispanic No Yes
Number/Street/Apt. Race White Black Asian
City/State/ZipCode Am. Indian/Nat. Alaskan.
 Other: _____
 New telephone () _____ Date of expected arrival / /
 New health provider: Unknown Known (name, address, phone) _____
 Insurance source: None Medicaid Private Medicare Other _____
 Emergency contact: Name _____ Phone _____

Laboratory information for this referred case/suspect index case for this contact not applicable

| Date | Specimen type | Smear | Culture | Susceptibility | Chest X-ray | Other pertinent labs |
|------|---------------|-------|---------|----------------|-------------|----------------------|
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Site(s) of disease: Pulmonary Other(s) specify all _____
 Date 1st negative smear / / Not yet Date 1st negative culture / / Not yet
 TB skin test #1: Date / / Result mm TB skin test #2: Date / / Result mm

Contact/LTBI Information **TB Skin test** Not Done
 TST #1 Date / / Result mm TST #2 Date / / Result mm
CXR Not Done Date / / Normal Other: _____
 Last known exposure to index case / / Place/intensity of exposure: _____

Medications this referred case/suspect this referred contact/LTBI

| Drug | Dose | Start date | Stop date |
|------|------|------------|-----------|
| | | | |
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Planned completion date / /
DOT No Yes: start date / /
 Daily 1x W 2x W 3x W
 Last DOT Date / /
 Adherence problems/significant drug side effects:

Comments _____

Case Follow-Up In 30 days report to referring jurisdiction if located or not located and report final outcome.
Other Follow-Up Follow-up requested (form attached) No follow-up requested