MARYLAND LATENT TUBERCULOSIS TREATMENT RECORD

Please Print

Name: _____ DOB:_____ Date:_____
(Last) (First) (MI)

Address:_____City:_____ State:_____ Zip:_____

Phone #_____ Current Sex: ☐ Male ☐ Female Country of Origin_____

Foreign-Born: ☐ Yes ☐ No **Class A/B waiver:** ☐ Yes ☐ No **Date of US Arrival**: _____

Race/Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Needs interpreter
☐ Native Hawaiian or Other PI ☐ White ☐ Other ☐ Hispanic ☐ Non-Hispanic Language _____

TUBERCULIN SKIN TEST

Mantoux: Type ☐ Aplisol® ☐ Tubersol® Lot # _____
Exp. Date:_____ Date placed: _____
By:_____
Date read:_____Results read (mm): _____
By:_____

IGRA

IGRA: Type ☐ QFT ☐ T-SPOT
Date Drawn:_____
IGRA Results: ☐ Pos ☐ Neg ☐ Indeterminate/Borderline
Repeat Test (if done) : ☐ QFT ☐ T-SPOT Date _____
IGRA Results: ☐ Pos ☐ Neg ☐ Indeterminate/Borderline

Reason For Testing

☐ Contact ☐ School ☐ Work ☐ Foster Care ☐ Foreign-born Adoptee ☐ Class B ☐ Pre-immunosuppressive therapy
☐ Pre-transplant evaluation ☐ Foreign-born ☐ Refugee ☐ Drug treatment program ☐ Other: specify:

RISK FOR PROGRESSION (*CHECK ALL THAT APPLY*) ☐ No known risk

☐ HIV/AIDS ☐ Diabetes ☐ Kidney failure/Dialysis ☐ Steroids ☐ Total Gastrectomy/Intestinal Bypass
☐ Immunosuppressive therapy ☐ TNFα inhibitors ☐ Lung disease ☐ Head and Neck Cancer (current) ☐ Silicosis
☐ Non-injecting drug use ☐ Injecting drug use ☐ Current smoker ☐ Age ≤ 5 years ☐ Underweight (<10% normal)
☐ Excess alcohol ☐ Stable Abnormal chest x-ray **OR** CT scan consistent with healed TB
☐ Other: _____

Population Risk *(Check all that apply)*

☐ Inmate ☐ Corrections employee ☐ Long term care facility resident ☐ Health care worker ☐ Migrant worker
☐ Homeless/Homeless shelter resident ☐ Homeless shelter employee

Previous History of TB Treatment:

☐ No ☐ Unknown ☐ Yes Date:_____ ☐ TLTBI ☐ TB Disease
Drugs Used: ☐ Isoniazid ☐ Rifampin ☐ Pyrazinamide ☐ Rifapentine ☐ Ethambutol ☐ Other:_____
Completed Treatment: Date:_____
Discontinued Treatment: Date:_____
Reason for Discontinuing: ☐ Provider decision ☐ Medication allergy/intolerance ☐ Patient stopped of own accord
☐ Lost to follow-up within U.S. ☐ Moved out of country and lost to follow-up

CURRENT MEDICAL HISTORY *(Check all that apply)*

☐ **Excess alcohol use** # drinks/day____ x____years ☐ Stopped alcohol (year) _____
☐ **Smokes** # packs/day____ x____years ☐ Stopped smoking (year) _____ ☐ **Permanent lens replacement**
☐ **Hepatitis** (type/year if known) _____ ☐ **Seizures** ☐ **Soft contacts** ☐ **Pregnancy**
☐ **Pulmonary disease** ☐ **Previous TB treatment**(year) _____ ☐ **Gout** ☐ **Peripheral Neuropathy**
☐ **Diabetes** ☐ **Kidney Dialysis** ☐ **Allergies/Asthma** _____

HIV

Risk factors ☐ Yes ☐ No **Previously tested** ☐ Yes ☐ No Date:_____ Result:_____
HIV counseled ☐ Yes ☐ No **HIV tested** ☐ Yes ☐ No Date:_____ Result:_____
CD4 ☐ **No** ☐ **Yes** Date:_____ Result:_____ ☐ HAART (list medications on next page)
Viral load ☐ **No** ☐ **Yes** Date:_____ Result:_____

MARYLAND LATENT TUBERCULOSIS TREATMENT RECORD

Current Medications: ☐ Known Drug Allergies_____
☐ None ☐ Anti-Allergy/Anti-Asthma (specify)_____
☐ Birth Control Method _____ ☐ TNFa inhibitors _____
☐ Dilantin ☐ Methadone ☐ Antacids ☐ Steroids ☐ Anticoagulants ☐ Medications for Diabetes
☐ Anti-retroviral (list) _____
☐ Other medications:_____
☐ Non-prescription meds (taken routinely) _____
Comments:_____

Laboratory:

☐ LFT's ☐ Hepatitis panel ☐ CBC ☐ Other (specify) _____

Date:_____ Date:_____ Date:_____ Date:_____

Sputum ☐ Yes ☐ No ☐ Other (specify) _____

Date: _____ Results: AFB_____ Culture _____

Date: _____ Results: AFB_____ Culture _____

Date: _____ Results: AFB_____ Culture _____

CXR Date:_____
☐ Normal ☐ Abnormal

Chest CT Scan OR other Chest Imaging Study Date: _____
☐ Normal ☐ Abnormal ☐ Not Done

Pregnant ☐ Positive ☐ Negative ☐ N/A Pregnancy Test:_____

Patient/Guardian Signature:

TB Symptoms: ☐ None ☐ Loss of appetite ☐ Fever ☐ Cough lasting > 2 weeks ☐ Night sweats ☐ Fatigue
☐ Hemoptysis ☐ Shortness of Breath ☐ Lymphadenopathy ☐ Wt. Loss___# lbs OR # Kg _____

Comments:

ORDERS: **Directly Observed Preventive Therapy**? ☐ **Yes** ☐ **No**

☐ Isoniazid Dose_____ Freq _____ Duration_____ ☐ Other Medications (specify)_____
☐ Rifampin Dose_____ Freq _____ Duration _____ Dose_____ Freq _____ Duration _____
☐ Rifabutin Dose_____ Freq _____ Duration _____
☐ Rifapentine Dose_____ Freq _____ Duration_____
☐ Vitamin B6 Dose_____ Freq _____ Duration_____

Clinician Signature: **Date:**

Nurse Signature: **Date:**

☐ Possible adverse side-effects of the medications for treatment of TB latent infection have been discussed with me. I understand them and have had an opportunity to have my questions answered. I understand if any signs or symptoms of tuberculosis (TB) do occur I should immediately discontinue my medications and report to _____.
If I stop taking my medications for more than a week, I will contact my nurse or case manger before restarting my TB medications. I consent to take this medication for the prevention of TB.
☐ I understand that my TB infection will not go away and that if I do not take my medications I increase the risk I may develop active TB during my lifetime.

Patient/Guardian Name (Print) _____**Signature:** _____**Date:**_____

Health Department Witness:_____**Date:** _____

MARYLAND LATENT TUBERCULOSIS TREATMENT RECORD

DAILY / WEEKLY / MONTHLY ASSESSMENT (add additional sheets as needed)

Date:_____

Name:_____ **DOB:** _____
(Last) *(First)* *(MI)*

Date												
Assessment #	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Weight___lb.__Kg												
Loss of appetite												
Fatigue/malaise												
Nausea/vomiting												
Jaundice												
Scleral icterus												
Brown urine												
Rash												
Itching												
Fever												
Dizziness												
Numbness extremities												
Tingling extremities												
Joint pains												
Recent visual change												
Marked behavioral change												
Is patient pregnant?												
Last menstrual period												
ETOH intake												
Other (specify)												
Infection vs. disease												
Risk for progression												
Signs and Symptoms of active disease												
Diagnostic tests												
Medication side effects												
When to stop medication												
Nurse Initials												
Nurse Signature(s)												

PATIENT EDUCATION

MARYLAND LATENT TUBERCULOSIS TREATMENT RECORD

Discharge Summary Form

Name: _____ **DOB:**_____ **Date:** _____
(Last) (First) (MI)

SUMMARY OF TREATMENT OF LATENT TB INFECTION

Please show this form to your physician or to anyone who requests that you be tested for tuberculosis as a condition of employment or to enter school. If you were unable to complete your treatment it is still important that health care providers have your treatment history: because treatment for latent TB infection can be resumed at any time. The risk for developing active TB disease may change over the course of a person's lifetime or with the onset of certain illnesses.

Please contact your local health department if you have questions or concerns. Notify your physician if you start to experience two or more signs or symptoms of active tuberculosis occurring at the same time that do not go away. These include: a persistent cough lasting more than 2 weeks, onset of night sweats, general malaise or extreme tiredness, loss of appetite, sudden and unexpected weight loss of several pounds or kilograms, cough with brownish or reddish sputum. Make sure any health care provider you see is aware of your TB infection history and treatment**. Date started:** _____ **Date ended:** _____

Medications: ☐ Isoniazid ____mg ☐ Rifampin ____mg ☐ Rifapentine____mg ☐ Vitamin B6 ____mg. (daily)
☐ **Other**: (specify) _____

Frequency: ☐ Daily ☐ **2x** (twice) ☐ Weekly DOPT ☐ **3x** (thrice) weekly

Total doses/months ordered:_____ **Total doses taken/ months treated** _____

Treatment Completion Date:_____

Discontinued treatment: ☐ **No** ☐ **Yes** Date:_____

Reason for discontinuing: ☐ provider decision ☐ medication allergy/intolerance
☐ patient stopped of own accord ☐ lost to follow-up within U.S. ☐ moved out of country / lost to follow-up

Comments: _____
_____
_____

Provided by:_____ Local Health Department

Address: _____, Maryland, (zip code) _____

Phone:_____ Fax:_____

Other: (specify name/address if known) _____