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:       |
|  |
|       | 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: \_\_\_/\_\_\_/\_\_\_