Tuberculosis Control Program

EpiTrax Tuberculosis Infection Form

Please print clearly

Investigator Name: _____ **Epitrax Case Number: _____**

Date of Investigation: _____ **County & Facility:_____**

DEMOGRAPHIC TAB

Patient Name:_____ **Parent/Guardian_____**

Last, First, Middle

Address: _____

Street, City, Zip Code, County

Date of Birth: _____ **Birth Gender: _____** **Primary Language: _____**

Phone Number: _____

Please circle:

Ethnicity: **Hispanic** **Non-Hispanic**

Race: White **Black/African-American** **American Indian/Alaskan Native** **Asian** **Hawaiian/Pacific Islander**

Country of Birth:_____ **Date of Entry: _____**

Immigration Status (initial entry): **Refugee** **Student VISA** **Tourist VISA** **Family Finances VISA**
Employment VISA **Immigrant VISA** **Other: _____**

Patient lived outside the US for an uninterrupted period of > 2 years **Y** **N**

Parents of children under 15 years-of-age only:

Country of Birth: _____ **Country of Birth: _____**

(Birth Parent 1) **(Birth Parent 2)**

Emergency Contact Name: _____

Emergency Contact Relationship:_____

Emergency Contact Phone Number: _____ **ie. (###)###-####**

Does Patient have health insurance? Y N Company _____

CLINICAL TAB

Disease: (circle one) Active TB Suspect Infection (LTBI)

If Active TB is confirmed: Pulmonary or Extra-pulmonary (location)_____

Does Patient have TB symptoms? **Y N**

Please circle and date each symptom present:

Cough _____ Unexplained Weight Loss _____ Normal weight: _____

Current Weight: _____

Hemoptysis_____ Fever _____ Fatigue _____

Appetite Loss _____ Shortness of Breath _____ Night Sweats _____

Chest Pain _____ Other Symptoms (please specify):

Hospitalized: Y N Health Facility: _____

Admission Date: _____ Discharge Date: _____

Is the Patient Deceased? Y N Date of Death_____

Is the Patient Pregnant? Y N Expected Due Date: _____

Is the patient going to take TB treatment? Y N U/K

List TB Medications dosage and start dates on separate page

Clinician's Name:_____

Diagnostic Facility: _____

Medical History:

Previous TB tx? Y N date? _____ Received BCG vaccine? Y N

Pt. currently taking any meds? Y N History of Hepatitis? Y N

List medications on separate sheet A B C &/or Other

Medication Allergies? Y N

If yes, please list: _____ Date if HIV Test: _____

Diabetic? Y N circle one: Type 1 Type 2 HIV Test results: _____

Chronic Illnesses/Immune Problems? Y N

Please list chronic conditions on separate sheet

EPIDEMIOLOGICAL TAB

Risk Factors:

Reasons for current TST/IGRA? _____

If yes, document further information on a separate sheet:

History of smoking tobacco: Y N

History of IV drug use: Y N

History of Homelessness Y N

History of Extensive Travel Outside US Y N
List countries _____

History of non IV drug use: Y N

History of excessive alcohol use: Y N

Patient ever been in jail or prison: Y N

Patient ever lived in long term care facility Y N

Is patient a migrant/seasonal worker Y N

Has patient worked, volunteered in, or been a resident in: Healthcare Corrections Shelters

Describe type of facility patient worked, volunteered or lived: _____

Does the patient go to school? Y N Where? _____

Occupation during the last 12 months_____

Has the patient ever been a contact to someone with TB Disease? Y N _____

INVESTIGATION TAB

TST/IGRA, CXR/other Radiography – scan and attach reports. (Document scanning in Encounters.)

Previous TST: Y N U/K Date Read: _____ Millimeters of induration _____

Previous IGRA : Y N U/K Date: _____ QFT or T-Spot

Current TST: Y N U/K Date Read: _____ Millimeters of induration _____

ADDL. INFO

Current IGRA: Y N U/K Date: _____ QFT or T-Spot

Previous Chest- Xray: Y N U/K When? _____ Results? _____

Current Chest- Xray: Y N U/K When? _____ Results? _____

CT Scan: Y N U/K When? _____ Results? _____

Primary reason patient first evaluated for TB Disease? _____

_____

NOTES

Please fax all supporting documents to 785-559-4224: Hospital/Clinic Documents, Lab Work, TST/IGRA Reports, CXR/CT Scans, etc.