FLORIDA DEPARTMENT OF HEALTH — MDCHD — Miami-Dade County Health Dept.

TB CASE/SUSPECT REPORT

1 Reporting Entity

__/__/____ Reporting Date (MM/DD/YYYY) | ☐ Suspect | ☐ New Case | ☐ Reactivation | ☐ Transfer | Entity Name

( ) - Entity Phone Number | ( ) - Entity Fax Number | Reported by (Last Name, First Name)

2 Patient Demographics & Current Address

Last Name | First Name | Mi

Current Address (Number & Street Name) | Apt. Number

City | State | Zip Code

( ) - Home Phone Number

Country of Origin | If not US, Date arrived in USA: __/__/____ Format (MM/DD/YYYY or MM/YYYY)

Florida Resident: ☐ Yes ☐ No | If Yes, Date Arrived in Florida: __/__/____ Format (MM/DD/YYYY or MM/YYYY)

__/__/____ Date of Birth (MM/DD/YYYY) | ___-___-____ Social Security Number

Gender: ☐ Male ☐ Female | Marital Status: ☐ Single ☐ Married

Race: ☐ Amer. Ind. or Alaskan Native ☐ Asian or Pacific Isl. ☐ Black ☐ White

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Language Spoken if NOT English:

Homeless within past year: ☐ Yes ☐ No | Status at Diagnosis of TB: ☐ Alive ☐ Dead

3 Previous Address: *(Fill only if less than 6 months in Current Address)*

Previous Address (Number & Street Name) | Apt. Number | City | State | Zip Code

4 Occupation *(Check all that apply within the past 24 months.)*

☐ Health Care Worker ☐ Correctional Employee ☐ Migratory Agricultural Worker ☐ Unknown

☐ Student ☐ School Staff ☐ Restaurant Worker ☐

☐ Not Employed within the past 24 months. ☐ Other Occupation (specify)

5 Work Place

Institution Name | Suite Number

Number & Street Name | City

State | Zip Code | ( ) - Work Phone Number

6 Past Medical (TB) History

☐ Yes ☐ No | If Yes, When (Year) | Where: Country, State or County

BCG: ☐ Yes ☐ No | If Yes, Month & Year of BCG __/____ BCG Date (MM/YYYY)

Med Taken: ☐ 1 Drug ☐ 2 or more Drugs | Duration of Rx. | Specify (drug Name)

Previous PPD: ☐ Positive | If + Size in mm. | ☐ Negative __/____ PPD Date (MM/YYYY)

7 Current Supervision/ Meds./ PPD & X-ray

Meds. Supervision:

Physician's / Institution's Name

( ) - Phone Number | ( ) - Fax Number

__/__/____ Admission Date (MM/DD/YYYY) | __/__/____ Discharge Date (mm/DD/YYYY)

__/__/____ Chest X-ray Date (MM/DD/YYYY) | Results: ☐ Normal ☐ Abnormal ☐ Cavitary

Chest X-ray Comments.

Current TB Meds. Dosage/mg.:

INH	RIF	PZA	EMB

__/__/____ TB Medications Start Date

Other Medications & Dosage

Current Non TB Medications | Patient's weight: In Lbs.

Current PPD: __/__/____ Implant Date (MM/DD/YYYY)

__/__/____ Reading Date (MM/DD/YYYY) | Result in mm:

8 Bacteriology

Specimen: ☐ Sputum ☐ Other Tissue/Fluid

Smear: ☐ Pos. ☐ Neg. __/__/____ Result Date (MM/DD/YYYY)

Culture: ☐ Pos. ☐ Neg. __/__/____ Result Date (Diagnosis Date)

__/__/____ | Culture ID

Lab Name

( ) - Lab Phone Number | ( ) - Lab Fax Number

9 Site(s) of Disease

☐ Pulmonary ☐ Lymphatic Unknown ☐ Lymphatic Cervical ☐ Lymphatic Intrathoracic ☐ Lymphatic Other

☐ Pleural ☐ Bone & or Joint ☐ Genitourinary ☐ Miliary ☐ Meningeal

☐ Peritoneal ☐ Other (Specify)

10 HIV Status

__/__/____

☐ Positive ☐ Negative ☐ Indeterminate ☐ Refused ☐ Not Offered

☐ Test Done Results Unknown | If Positive, Based on: ☐ Medical Documentation ☐ Patient History

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11 Symptoms

☐ Asymptomatic ☐ Wt. Lost ____ Lbs. (Amount) Over ____ (Months) ☐ Pleurisy

☐ Cough ☐ Fatigue ☐ Hemoptysis ☐ Fever ☐ Anorexia ☐ Fistula

☐ Night Sweat ☐ Shortness of breath ☐ Other ____

12 Alcohol / Drug Use

Intra-Venous drug use: ☐ Yes ☐ No Date Last Use (MM/YYYY)

Non Injection drug Use within past year: ☐ Yes ☐ No Date Last Use (MM/YYYY)

Excess Alcohol Use within past year: ☐ Yes ☐ No Date Last Use (MM/YYYY)

13 Contact to TB Case

Ever Exposed to a TB Case? ☐ Yes ☐ No How long? ____ (Months) Last Name | First Name | Relationship

Did any family member die with TB? ☐ Yes ☐ No Date of last Contact: __/__/____ Format (MM/YYYY)

14 Other Medical Conditions

Previously Diagnosed with Liver Disease: ☐ Yes ☐ No

If "Yes", What & When? ____ __/____ Format (mm/yyyy)

☐ Gastrectomy ☐ Diabetes Mellitus ☐ Renal Failure

☐ Organ Transplant ☐ Pregnant Expected time of Deliverv __/____

☐ Epilepsy __/____ Last Episode Date (mm/yyyy) ☐ Allergies ____ Name

☐ Immunosuppressive Medications ☐ Silicosis (Occupational Lung Disease)

☐ Jejuoileal Bypass ☐ Cancer of Head, Neck or Lung

☐ Other, Specify ____

15 Correctional Facility

(A) Was the client incarcerated during their infectious period: ☐ Yes ☐ No

If 'Yes', Where ?: ☐ Federal Prison ☐ Local Jails ☐ Other Correctional Facility ☐ State Prison ☐ Juvenile Correctional Facility

Correctional Facility Name

( ) - Correctional Facility Phone Number ( ) - Correctional Facility Fax Number

16 Long Term Care Facility

(A) Resident of Long Term Care Facility at time of Diagnosis: ☐ Yes ☐ No

(B) Resident of Long Term Care Facility within the last 2 Years: ☐ Yes ☐ No

If 'Yes' to A or B: ☐ Nursing Home ☐ Hospital ☐ Residential ☐ Mental Health ☐ Alcohol/Drug Treatment ☐ Other Long Term Care Facility

Long Term Care Facility Name

( ) - Long Term Care Facility Phone Number ( ) - Long Term Care Facility Fax Number

17 Emergency Contacts

Last Name | First Name | Relationship | ( ) - Phone Number | Other Information

Last Name | First Name | Relationship | ( ) - Phone Number | Other Information

18 Comments

FOR DOH USE ONLY

TB IMS Case Number: ____ (Current Year) - ____

Within City Limit: ☐ Yes ☐ No

Diagnosis for Case Register

__/__/____ Date Submitted to Tallahassee

2 0 __ __ D A D ___ County Case Number

Report Received by: Last Name | First Name

__/__/____ Interview Date

Interviewer's Name | Interviewer's Signature

Updated by

1. Name — __/__/____ Date (mm/dd/yyyy)

2. Name — __/__/____ Date (mm/dd/yyyy)

3. Name — __/__/____ Date (mm/dd/yyyy)

4. __/__/____ Date (mm/dd/yyyy)

Send report to: MDCHD/TB Program 1350 NW. 14th. Street, Unit #8, Miami, FL 33125 Tel. (305) 324-2470 Fax: (305) 547-5571

If you have any question or need clarification about this form, contact: (305) 324-2470