N.C. Department of Health and Human Services
Division of Public Health
Epidemiology Section • TB Control

# Tuberculosis Epidemiological Record

1905 Mail Service Center
Raleigh, NC 27699
919-755-3184 Ext. 103
Fax: 919-733-0084

**Patient Name: _____ Date of Birth: _____ Phone Number: _____**

**Medical Record Number: _____ NCEDSS Number:_____ Preferred Language: _____ Interpreter Needed ☐ Yes ☐ No**

**Country of Birth**
_____

**Sex at Birth**
☐ Male ☐ Female ☐ Other:

**Address:** _____
**City:** _____ **County:** _____ **State:** _____
**Zip:** _____
**Occupation:** _____
**Employer/School Address:** _____
**City:** _____ **County:** _____ **State:** _____
**Zip:** _____

**Ethnicity**
☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a

**Race (Select one or more)**
☐ American Indian/Alaska Native ☐ Asian
☐ Black/African American ☐ White
☐ Native Hawaiian/Pacific Islander

**Ever worked in**:
Healthcare ☐ Yes ☐ No
Prison/Jail ☐ Yes ☐ No
Migrant/Seasonal ☐ Yes ☐ No

Travel for more than 30 days: ☐ Yes ☐ No If yes, country visited: _____
Country of previous residency for more than 60 days: _____
Country of birth for Guardian(s) of patients <15 years old: _____

**Contact to a case?**
☐ Yes ☐ No
Year of contact: _____
Source case name: _____
NCEDSS Event Number:

**PCP:**
If no PCP, was a referral made to get patient into care?
☐ Yes ☐ No

**Reason for presenting to TB clinic:**
☐ Job/administrative screening ☐ Contact investigation ☐ Refugee/Class B ☐ Medical risk for TB
☐ Outreach screening ☐ Confirmed active TB ☐ Population risk for TB
☐ Suspected active TB ☐ Referred by healthcare provider ☐ Other:

**Smoking History and Tobacco Use**:
☐ Current ☐ Former ☐ Never
**Type:** _____
**(Cigarettes, cigars, e-cigarettes, snuff, chewing tobacco, pouches, etc.)**

**Tuberculin Skin Test (TST):**
Date Placed:
Date Read:
Result: _____ mm
Date Placed:
Date Read:
Result: _____ mm
☐ Positive ☐ Negative
☐ TST not done

**Interferon Gamma Release Assay (IGRA):**
☐ QuantiFERON ☐ T-Spot
Date Collected:
Date Resulted:
☐ Positive ☐ Negative
☐ Indeterminate
☐ Borderline (T-Spot)
☐ IGRA not done

**History of Negative TST/IGRA**
☐ Yes ☐ No **Date:** _____
**History of Positive TST/IGRA**
☐ Yes ☐ No **Date:** _____
**History of TB Disease/TB Infection**
☐ TB Disease **Year** _____ ☐ TB Infection **Year** _____
**Prior treatment for TB Infection**
☐ No ☐ Yes **Year** _____
**Prior treatment for TB Disease**
☐ No ☐ Yes **Year** _____

**HIV Test Date:** _____
**HIV test results:**
☐ Positive ☐ Negative ☐ Indeterminate
☐ Refused ☐ Not Offered ☐ Result pending
**If positive:**
CD4 count: _____ Date: _____
On ART? ☐ Yes ☐ No
If no, was referral made?
☐ Yes ☐ No
HIV medication(s): _____

## SOCIAL RISK HISTORY

**Has the patient ever worked or resided in: (if yes, list below)**

☐ Yes ☐ No Long-term/assisted living facility: _____
☐ Yes ☐ No Correctional facility: _____
☐ Yes ☐ No Hospital based facility: _____
☐ Yes ☐ No Mental health/alcohol/drug treatment facility: _____
☐ Yes ☐ No Other type of residential facility: _____

**Within the past 12 months has the patient:**

☐ Yes ☐ No Been homeless or **ever** homeless
☐ Yes ☐ No Used injection drugs
☐ Yes ☐ No Used other non-injected illicit drugs
☐ Yes ☐ No Used alcohol heavily
(>2 drinks every day or >4 drinks in a day more than twice a month)

## TB SYMPTOMS

☐ Yes ☐ No Cough lasting at least 3 weeks (# weeks of cough: ____)
☐ Yes ☐ No Hemoptysis
☐ Yes ☐ No Persistent fever
☐ Yes ☐ No Night sweats
☐ Yes ☐ No Chest pain
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Poor appetite
☐ Yes ☐ No Unintentional Weight loss (amount ____ lbs)
☐ Yes ☐ No Swollen glands in neck
☐ Yes ☐ No Cervical lymphadenopathy on nurse exam

Symptom onset date: _____
Weight: _____ Height: _____ BMI: _____

Nurse: _____
Signature: _____
Date: _____

## MEDICAL HISTORY

☐ Yes ☐ No Solid organ transplant recipient
☐ Yes ☐ No Underweight
☐ Yes ☐ No End-stage renal disease (on dialysis)
☐ Yes ☐ No Gastrectomy / jejunal bypass
☐ Yes ☐ No Pregnant LMP: _____
☐ Yes ☐ No Using birth control Type: _____
☐ Yes ☐ No Currently breastfeeding
☐ Yes ☐ No Lung disease (name)
☐ Yes ☐ No Hepatitis B or C (chronic or acute)
☐ Yes ☐ No Other liver disease
☐ Yes ☐ No Diabetes mellitus
If yes, HgbA1C : _____ Date: _____
☐ Yes ☐ No Chronic malabsorption syndrome
☐ Yes ☐ No Recent or current TNF-alpha antagonist therapy
☐ Yes ☐ No Immunosuppressed/ immunocompromised due to a medical condition (e.g., leukemia, Hodgkin's lymphoma, carcinoma of the head or neck), or immunosuppressive therapy such as prolonged use of high doses of corticosteroid (> 15 mg/day))

Other Conditions:
_____

Allergies:
_____

Medications: (Please specify NON-TB medications, include dosage)
_____
_____
_____
_____
_____
_____

**Patient Name: _____ Medical Record Number: _____ NC EDSS Number: _____**

**DIAGNOSIS AND EVALUATION**
**ALL PATIENTS ARE TO BE MONITORED PER NC STATE AND COUNTY TB POLICIES**

□ **Initial Chest Radiograph** □ **End of Treatment Chest Radiograph**
Date: _____
□ Normal □ Cavity □ Mediastinal lymphadenopathy
□ Abnormal □ Infiltrate □ Pleural thickening □ Pleural effusion
□ Granuloma □ Scarring □ Atelectasis □ Nodules
□ Evidence of miliary TB □ Other: _____
**Prior Chest Radiograph**
Date**:** _____ Comparison: □ Improved □ No change □Worsening

**Medical Provider Notes and Examination**

**Diagnosis:**
□ Confirmed active TB (Specify site): _____ □ Suspected active TB □ Latent TB □ Evaluation in progress □ No further TB follow-up needed

**ORDERS**

**Blood Tests:**
□ Complete blood count (CBC): □ Baseline □ Monthly □ Other: _____
□ Metabolic chemistry panel (includes creatinine and glucose): □ Baseline □ Monthly □ Other: _____
□ Liver function test: □ Baseline □ Monthly □ Other: _____
□ Other test: _____ □ Baseline □ Monthly □ Other: _____
**Bacteriology: (AFB Smears and Cultures)**
□ Collect three (3) sputum specimens with an interval of at least eight hours between specimen collections. At least one should be an early morning specimen.
□ Collect two (2) sputum specimens every two weeks after the initial 3 sputum specimens and until 2 consecutive sputum **cultures** are negative.
**Airborne Precautions:** □ Respiratory isolation □ No respiratory isolation needed
**Medication Administration:** □ DOT □ Video Directly Observed Therapy (VDOT)

**LTBI TREATMENT**

| | | |
|---|---|---|
| □ Isoniazid _____mg + Rifapentine _____mg po **once weekly x 12 weeks** | □ Directly observed | □ Self-administered |
| □ Rifampin _____mg po x 4 months **daily** | □ Directly observed | □ Self-administered |
| □ Isoniazid _____mg + Rifampin _____mg po **daily x 12 weeks** | □ Directly observed | □ Self-administered |
| □ Isoniazid _____mg po x 6 months □ **daily** □ **twice weekly** | □ Directly observed | □ Self-administered |
| □ Isoniazid _____mg po x 9 months □ **daily** □ **twice weekly** | □ Directly observed | □ Self-administered |
| □ Isoniazid _____mg + Rifapentine _____mg po once-weekly x **30 days** | □ Directly observed | □ Self-administered |

**ACTIVE TB TREATMENT**

**Expected Duration of Treatment:** _____ weeks **Treatment Start Date: _____**

**Intensive Phase: Daily**
□ Isoniazid _____ mg po daily x 8 weeks (40 doses must be DOT; 56 doses total)
□ Rifampin _____ mg po daily x 8 weeks (40 doses must be DOT; 56 doses total)
□ Pyrazinamide _____ mg po daily x 8 weeks (40 doses must be DOT; 56 doses total)
□ Ethambutol _____ mg po daily x 8 weeks (40 doses must be DOT; 56 doses total)
□ Pyridoxine (Vit B6) _____ mg po daily x 8 weeks (40 doses must be DOT; 56 doses total)
□ Other:
□ Other:

**Continuation Phase: Daily**
□ Isoniazid _____ mg po daily x _____ weeks
□ Rifampin _____ mg po daily x _____ weeks
□ Pyridoxine (Vit B6) _____ mg po daily x _____ weeks
□ Other:
□ Other:

**Alternative Continuation Phase**
□ Isoniazid _____ mg po thrice weekly x _____ weeks
□ Rifampin _____ mg po thrice weekly x _____ weeks
□ Pyridoxine (Vit B6) _____ mg po daily x _____ weeks
□ Other:
□ Other:

**Provider's Signature: _____**
**Date:** _____

**How to count doses:**
**During intensive phase, count DOSES**. To complete 8 weeks of intensive phase, the patient must ingest 40 doses directly observed. No more than five doses each week (defined as starting on Sunday and ending the following Saturday) may count toward the 40 required doses. If more than two consecutive weeks are missed during intensive phase, counting must restart at zero doses received.
**During continuation phase, count WEEKS**. The week begins on Sunday and ends on the following Saturday. A week of therapy can count toward completion of treatment under the following circumstances:

- If the patient is receiving daily therapy, at least five daily doses of therapy are observed (four doses is acceptable if a holiday or other one-day closure, such as due to adverse weather, falls during that week and the patient is self-medicating on weekends also).
- If the patient is receiving therapy three times weekly, if three doses were observed during the week and each dose was separated from the next dose by at least a day.
- If the patient is receiving therapy three times weekly, up to two weeks may be counted in which only two doses were received, if those doses were at least 72 hours apart.
- If more than three consecutive months (12 weeks) are missed in the continuation phase, the entire course of treatment must be started over from the beginning.