***[Replace this text with your organization’s identifier.]***

Index TB case no.:

(For health department use only)

**PRIVATE PROVIDER TUBERCULOSIS EVALUATION FORM**

(To be completed by private physician)

**PLEASE RETURN THIS FORM TO:**

***[Insert Agency name, address, and secure fax number, Attn. to:]***

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

Medical Evaluation Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

**TB Symptom Screen (tick all that apply):**

* Cough for more than three weeks
* Pain in the chest
* Blood in sputum
* Weakness
* Tiredness
* Swollen lymph node
* Unexpected weight loss
* Decreased appetite
* Poor growth
* Fever
* Chills
* Sweating at night
* Other: \_\_\_\_\_\_\_\_\_\_\_
* None of the above

**Tuberculin Skin Test (TST):** Administered: \_\_\_/\_\_\_/\_\_\_; \_\_\_\_\_\_\_\_\_ Read: \_\_\_/\_\_\_/\_\_\_ ; \_\_\_\_\_\_\_\_\_

(date) (time) (date) (time)

TST Result: \_\_\_\_\_\_mm (record in millimeters, induration only)

**OR**

**IGRA Test:** Date: \_\_\_/\_\_\_/\_\_\_\_\_ Result: ❑Negative ❑ Positive ❑Indeterminate

*If TB symptoms are present* **OR** *either TST or IGRA test result is positive, please obtain chest X-ray and indicate findings below.*

**Chest x-ray** Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: ❑Normal ❑Abnormal: (If abnormal, ❑Cavitary or ❑Non-cavitary)

**Diagnosis:**

❑TB exposure/no infection (TB1); ❑TB infection/no disease (TB2); ❑Active TB (TB3); ❑Inactive TB (TB4); ❑Possible TB, needs further evaluation (TB5)

**Treatment:** ❑No ❑Yes - If yes, treatment regimen:

**Prevent TB cases by finding and treating people with LTBI! Preferred treatment is a short course regimen:**

• Isoniazid + Rifapentine weekly x 12 weeks *OR* • Rifampin daily x 4months

If a rifamycin-based regimen is not an option (due to drug resistance or intolerance), use Isoniazid daily x 9 months.

For more information about LTBI treatment regimens, contact your local TB program or CDC website.

Date medication started \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Name of physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_