Florida Department of Health TB Medical Report and Treatment Plan Reporting Form

Chapter 392.64 F.S. & Chapter 64D-3.043 F.A.C.

Medical Evaluation

1. Relevant Medical & Social History

Reason for Evaluation:

☐ Signs/Symptoms suggestive of active TB
- ☐ Cough ☐ Hoarseness ☐ Chest pain
- ☐ Shortness of breath ☐ Fever ☐ Loss of appetite
- ☐ Unintentional weight loss _____ lbs or_____ kg
- ☐ Overwhelming Fatigue ☐ Drenching night sweats
- ☐ Other _____

☐ Imaging studies suggestive of active TB.

☐ Laboratory findings suggestive of active TB.

☐ Laboratory findings confirming active TB.

☐ History of TB exposure or positive TB test

☐ History of TB treatment

☐ TB Infection ☐ TB Disease

Treatment Records Available? ☐ Yes (attach) ☐ No

☐ Allergies _____ ☐ No Known Allergies

☐ Tobacco use _____

Risk Factors for TB Exposure ☐ None

☐ Known history of TB exposure.

☐ Country of birth _____
Date of U.S. Arrival: _____

☐ Travel outside of the U.S. > 60 days

☐ Lived or ☐ Worked in a congregate setting.
(Corrections, Homeless Shelter, Substance Abuse, Nursing)
Setting_____

☐ History of homelessness ☐ Within the last year

☐ Occupation type: _____

Risk Factors for Progression ☐ None

☐ HIV/AIDS ☐ Organ transplant ☐ Silicosis

☐ Diabetes ☐ Severe kidney disease

☐ Gastrectomy/Ileal Bypass

☐ Rheumatoid Arthritis or Crohn's

☐ Substance Use (specify) _____

☐ Head/Neck/Lung cancer ☐ Leukemia/Lymphoma

☐ Immunosuppressive medications (steroids/biologics)

☐ Low body weight (> 10% below ideal)

2. Testing (including pre-treatment baseline)

☐ TB Blood Test/Type: _____ ☐ TB Skin Test

Date: _____ Date: _____

Result: _____ Result: _____mm

Current Wt.: ____ lbs _____kg Date: _____

☐ HIV Test ☐ HgbA1C ☐ Hepatitis Panel

☐ CBC with Diff ☐ CMP ☐ Vitamin D

☐ Uric Acid (if PZA prescribed)

Vision Screenings: (If Ethambutol or Rifabutin prescribed)

Snellen Exam: ☐ Corrected **or** ☐ Uncorrected

Right _____ Left _____ Both _____

Red/green colorblindness (EMB only): ☐ Yes ☐ No

3. Radiographic Imaging*

☐ Chest X-ray (one view) ☐ Chest x-ray (two view)

☐ Other: _____

Date(s): _____

Provider: _____

*Provide CD with image files if available.

4. Microbiology*

☐ Sputum ☐ Pulmonary specimen (other)

☐ Extra-Pulmonary specimen Site: _____

☐ NAAT (i.e. GeneXpert or other Real-Time PCR)

☐ AFB Smear & Culture

☐ Molecular/Conventional Drug-susceptibility (DST)

*If TB risk factors present, send 3 sputum samples to the Bureau of Public Health Laboratories (BPHL) in Jacksonville, FL for testing. M. TB isolates must also be sent to BPHL.

Results (please attach):

NAAT ☐ Positive ☐ Negative ☐ Not ordered*

AFB Smear ☐ Positive ☐ Negative

AFB Culture ☐ Positive ☐ Negative ☐ Pending

5. Other testing: _____

Site of Potential/Confirmed Disease

☐ Pulmonary Isolation Date: _____

☐ Extra-Pulmonary Site: _____

TB Classification/Diagnosis*

☐ Presumptive TB disease (evaluation in progress)

☐ Active TB disease; Microbiology Lab-Confirmed

☐ Active TB disease; Clinically Confirmed (cultures neg)

☐ Not TB disease; Final Diagnosis: _____

*Report findings suggestive of active TB disease as presumptive disease until confirmed otherwise by the Department. Order NAAT on at least one sample (2 preferred) regardless of smear result. TB evaluations should be complete (with AFB cultures finalized) within 10-12 weeks of reporting. If TB disease has been ruled out, document the diagnosis that explains the clinical syndrome.

TB Care/Treatment Plan Goals*

☐ Prevent potential community transmission

☐ Assure timely diagnosis & treatment – Evaluation in progress to confirm or rule out TB

☐ Presumptive Treatment/re-evaluate in 8 weeks
(aids in ruling out/confirming culture negative TB disease)

☐ Treat to cure

*Goals of the TB care/treatment plan must be achieved using the least restrictive means to rule out or cure TB. DOT is required if treatment is prescribed, regardless of the treating provider.

TB Treatment Initiation Decision

☐ Yes: Start Date: _____
(Enter regimen information using DH 1173 Part 2)

☐ No: Deferred pending further evaluation

Review and complete applicable sections of form *DH 1173 Part 2 Treatment Plan/Status Report*, which includes a list of services offered by the Department.

Direct Contact Information:

Reporting Agency: _____

Reporting Provider: _____

Office: _____ Fax: _____

Mobile: _____

Business hours: _____

Clinician signature: _____

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

Race: _____ **Sex:** _____ **Address:** _____

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Treatment Status

☐ Deferred/pending further evaluation
☐ Treatment in progress Changes: ☐ Yes ☐ No
☐ Treatment stopped; Reason _____
Date: _____
Treatment completed to date: _____ weeks

☐ **Initial or** ☐ **Current Regimen** (Attach records)

Regimen*	**Frequency**
☐ Rifampin (RIF) _____mg	_____
☐ Isoniazid (INH) _____ mg	_____
☐ Pyrazinamide (PZA) _____ mg	_____
☐ Ethambutol (EMB) _____ mg	_____
☐ Other _____	

Expected Duration: ☐ 26 wks. ☐ 39 wks. ☐ 52 wks.
☐ Other: _____
*RIPE is the acronym used to describe the 4-drug regimen. Rifabutin may be substituted for RIF in certain situations.

Type of Supervision

☐ DOT* Specify Type: ☐ In-person ☐ Video-assisted
☐ None
*DOT: A health care worker must supervise the ingestion of all TB medications, and document monitoring for side effects response to treatment, if treatment is prescribed.

Medication Tolerance (if applicable)

☐ No adverse reactions or side effects reported
☐ Adverse reactions or side effects reported
Describe: _____
_____
(Attach records describing interventions and effectiveness)

Clinical Monitoring/Follow-up Plan (attach results)

☐ Monthly or ☐ Weekly: Weight _____ Lbs/ _____ Kg
☐ Monthly Follow-up Assessments
☐ Monthly or ☐ Weekly Sputum Collection
☐ Clinical Labs (if clinically indicated)
☐ Drug Screening (if applicable) Type: _____
☐ Therapeutic Drug Level Monitoring (if applicable)

Clinical Response to Treatment

☐ Unchanged from baseline ☐ Asymptomatic
☐ Improved (☐ Symptoms ☐ Radiography ☐ Weight gain)
Sputum Culture Conversion Date*: _____
*Collection date for the first of two or three consecutively negative final cultures reported if initial cultures were positive
☐ Clinical Worsening (☐ Symptoms/☐ Radiography)
☐ Not applicable (N/A)

Compliance with Plan of Care

☐ Compliant
☐ Non-compliant*
Specify: _____
*May require legal intervention

Other Monitoring _____
_____

Public Health Services Available (specify needs below)

☐ Isolation Guidance
☐ TB Case Management & Education (Required)
☐ Assistance with Individualized Plan of Care
☐ Medical Guidance or Consultation (1-800-4TB-INFO)
☐ TB Microbiology Lab Services (Required)
☐ Radiology or other Diagnostic Imaging Services
☐ Clinical Lab Testing
(Includes, but not limited to CBC w/diff, CMP, Hepatitis Panel, HIV, HgbA1C, Uric Acid, Vitamin D Level)
☐ Vision screening/monitoring (Snellen and Ishihara)
☐ Medication Assistance
☐ Issue starter pack ☐ Ongoing treatment ☐ DOT
☐ Contact or Source Case Investigation (CI/SCI) *
☐ Review for Legal Intervention
☐ Therapeutic Drug Level Testing
☐ Comprehensive TB Care

*CI is required for lab-confirmed cases of pulmonary TB or exposure to infectious aerosols during procedures, unless otherwise directed by the Department of Health. SCI is required if TB disease is identified in young children with unknown exposure.

Measurable Objectives for TB Treatment

- For patients with a positive AFB sputum smear result, initiate TB treatment within 7 days of the specimen collection date.
- Known HIV status
- Patients are started on RIPE, the recommended initial 4- drug regimen.
- Sputum culture conversion within 60 days of initiating treatment (or symptom and radiographic improvement within 60 days if initial cultures were negative).
- Completion of an effective multi-drug treatment regimen over the correct amount of time to cure TB, based on site of disease, drug-susceptibility, and compliance. (Requires CHD supervision via DOT /VDOT to verify)

Additional Notes

_____
_____

Update DH 1173 Part 2 once monthly, or as requested by the Department.

Direct Contact Information:

Reporting Agency: _____
County: _____
Reporting Clinician: _____
Office: _____ Fax: _____
Mobile: _____
Business hours: _____
Clinician signature: _____

Health Department Use Only

County: _____
Case Manager Assigned: _____
Phone: _____ Fax: _____
Attention: _____

Patient Name: _____ **Date of Birth:** _____
Race: _____ **Sex:** _____ **Address:** _____