TEXAS Department of State Health Services

TB Program Evaluation

Report of Follow-up and Treatment for Contacts to TB Cases and Suspects

Page ___ of ___

Date __ __/__ __/__ __ __ __

Case/Suspect Information

Last Name	First Name	Middle Name	DOB	SSN
			__ __/__ __/__ __ __ __	__ __ __-__ __-__ __ __ __

C. Contact Information

Contact 1

__ __ __-__ __-__ __ __ __ SSN

Last Name First Middle

DOB __ __/__ __/__ __ __ __

Gender ☐ Male ☐ Female Site # _____

Race _____

☐ Hispanic/Latino ☐ Not Hispanic/Latino

Date Identified: __ __/__ __/__ __ __ __

Relation to case:

BCG ☐ Yes ☐ No Date: __ __/__ __/__ __ __ __

Address

City County or Country

Phone #: ☐ Work ☐ Home

Country of Birth (if not US):

Exposure Length
☐ >6 hrs/wk
☐ >2 but <6 hrs/wk
☐ <2 hrs/wk
☐ No contact was made

Exposure Setting
Indoors: ☐ Size of car ☐ Size of bedroom ☐ Size of house ☐ Larger than house
☐ Outdoors

Ongoing exposure? ☐ Yes ☐ No

If no, date last exposure __ __/__ __/__ __ __ __

900 Test Results ☐ Pos ☐ Neg ☐ Unk

Priority (H, M, L):

History of positive TST? ☐ Yes ☐ No

Date __ __/__ __/__ __ __ __

TST/IGRA Date	mm/%	Pos	Neg
__ __/__ __/__ __ __ __	_____	☐	☐
__ __/__ __/__ __ __ __	_____	☐	☐
__ __/__ __/__ __ __ __	_____	☐	☐

CXR Date __ __/__ __/__ __ __ __ ☐ Normal ☐ Abnormal

☐ PA ☐ Lateral ☐ Lordotic ☐ Other

Evaluation Complete? ☐ Yes ☐ No

If No, Reason Not Complete:
☐ Died ☐ Lost to Follow-up ☐ Refused Evaluation ☐ 1st TST not done/read
☐ 2nd TST not done/read ☐ 3rd TST not done/read ☐ No Chest X-Ray

Treatment Recommended? ☐ Yes ☐ No

Reason Treatment not started:
☐ Contraindicated ☐ Died ☐ History of noncompliance ☐ Lost to follow-up ☐ Prior adequate treatment ☐ Refused treatment

ATS Class
☐ 0 ☐ 3 ☐ 1 ☐ 4 ☐ 2 ☐ 5

Treatment Outcome (if recommended)
☐ Completed adequate therapy
☐ Lost/patient not located
☐ Refused (patient chose to stop meds
☐ Refused (patient chose to stop evaluation)
☐ Adverse treatment event
☐ Died
☐ Moved out of state/country
☐ Provider decision-pregnant
☐ Provider decision-other (specify): _____
☐ No further evaluation needed
☐ Active TB developed

Treatment Started: __ __/__ __/__ __ __ __

Treatment Stopped: __ __/__ __/__ __ __ __

Months Recommended: _____

Months RX Completed: _____

Clinic:

Contact 2

__ __ __-__ __-__ __ __ __ SSN

Last Name First Middle

DOB __ __/__ __/__ __ __ __

Gender ☐ Male ☐ Female Site # _____

Race _____

☐ Hispanic/Latino ☐ Not Hispanic/Latino

Date Identified: __ __/__ __/__ __ __ __

Relation to case:

BCG ☐ Yes ☐ No Date: __ __/__ __/__ __ __ __

Address

City County or Country

Phone #: ☐ Work ☐ Home

Country of Birth (if not US):

Exposure Length
☐ >6 hrs/wk
☐ >2 but <6 hrs/wk
☐ <2 hrs/wk
☐ No contact was made

Exposure Setting
Indoors: ☐ Size of car ☐ Size of bedroom ☐ Size of house ☐ Larger than house
☐ Outdoors

Ongoing exposure? ☐ Yes ☐ No

If no, date last exposure __ __/__ __/__ __ __ __

900 Test Results ☐ Pos ☐ Neg ☐ Unk

Priority (H, M, L):

History of positive TST? ☐ Yes ☐ No

Date __ __/__ __/__ __ __ __

TST/IGRA Date	mm/%	Pos	Neg
__ __/__ __/__ __ __ __	_____	☐	☐
__ __/__ __/__ __ __ __	_____	☐	☐
__ __/__ __/__ __ __ __	_____	☐	☐

CXR Date __ __/__ __/__ __ __ __ ☐ Normal ☐ Abnormal

☐ PA ☐ Lateral ☐ Lordotic ☐ Other

Evaluation Complete? ☐ Yes ☐ No

If No, Reason Not Complete:
☐ Died ☐ Lost to Follow-up ☐ Refused Evaluation ☐ 1st TST not done/read
☐ 2nd TST not done/read ☐ 3rd TST not done/read ☐ No Chest X-Ray

Treatment Recommended? ☐ Yes ☐ No

Reason Treatment not started:
☐ Contraindicated ☐ Died ☐ History of noncompliance ☐ Lost to follow-up ☐ Prior adequate treatment ☐ Refused treatment

ATS Class
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Treatment Outcome (if recommended)
☐ Completed adequate therapy
☐ Lost/patient not located
☐ Refused (patient chose to stop meds
☐ Refused (patient chose to stop evaluation)
☐ Adverse treatment event
☐ Died
☐ Moved out of state/country
☐ Provider decision-pregnant
☐ Provider decision-other (specify): _____
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Treatment Started: __ __/__ __/__ __ __ __

Treatment Stopped: __ __/__ __/__ __ __ __

Months Recommended: _____

Months RX Completed: _____

Clinic:

Contact 3

__ __ __-__ __-__ __ __ __ SSN

Last Name First Middle

DOB __ __/__ __/__ __ __ __

Gender ☐ Male ☐ Female Site # _____

Race _____

☐ Hispanic/Latino ☐ Not Hispanic/Latino

Date Identified: __ __/__ __/__ __ __ __

Relation to case:

BCG ☐ Yes ☐ No Date: __ __/__ __/__ __ __ __

Address

City County or Country

Phone #: ☐ Work ☐ Home

Country of Birth (if not US):

Exposure Length
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☐ <2 hrs/wk
☐ No contact was made

Exposure Setting
Indoors: ☐ Size of car ☐ Size of bedroom ☐ Size of house ☐ Larger than house
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Ongoing exposure? ☐ Yes ☐ No

If no, date last exposure __ __/__ __/__ __ __ __

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Date __ __/__ __/__ __ __ __

TST/IGRA Date	mm/%	Pos	Neg
__ __/__ __/__ __ __ __	_____	☐	☐
__ __/__ __/__ __ __ __	_____	☐	☐
__ __/__ __/__ __ __ __	_____	☐	☐

CXR Date __ __/__ __/__ __ __ __ ☐ Normal ☐ Abnormal

☐ PA ☐ Lateral ☐ Lordotic ☐ Other

Evaluation Complete? ☐ Yes ☐ No

If No, Reason Not Complete:
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Reason Treatment not started:
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Treatment Started: __ __/__ __/__ __ __ __

Treatment Stopped: __ __/__ __/__ __ __ __

Months Recommended: _____

Months RX Completed: _____

Clinic: